

# Provider Manual

Medicare | Individual and Family Plans | Medicaid | CHIP

Jefferson Health Plans

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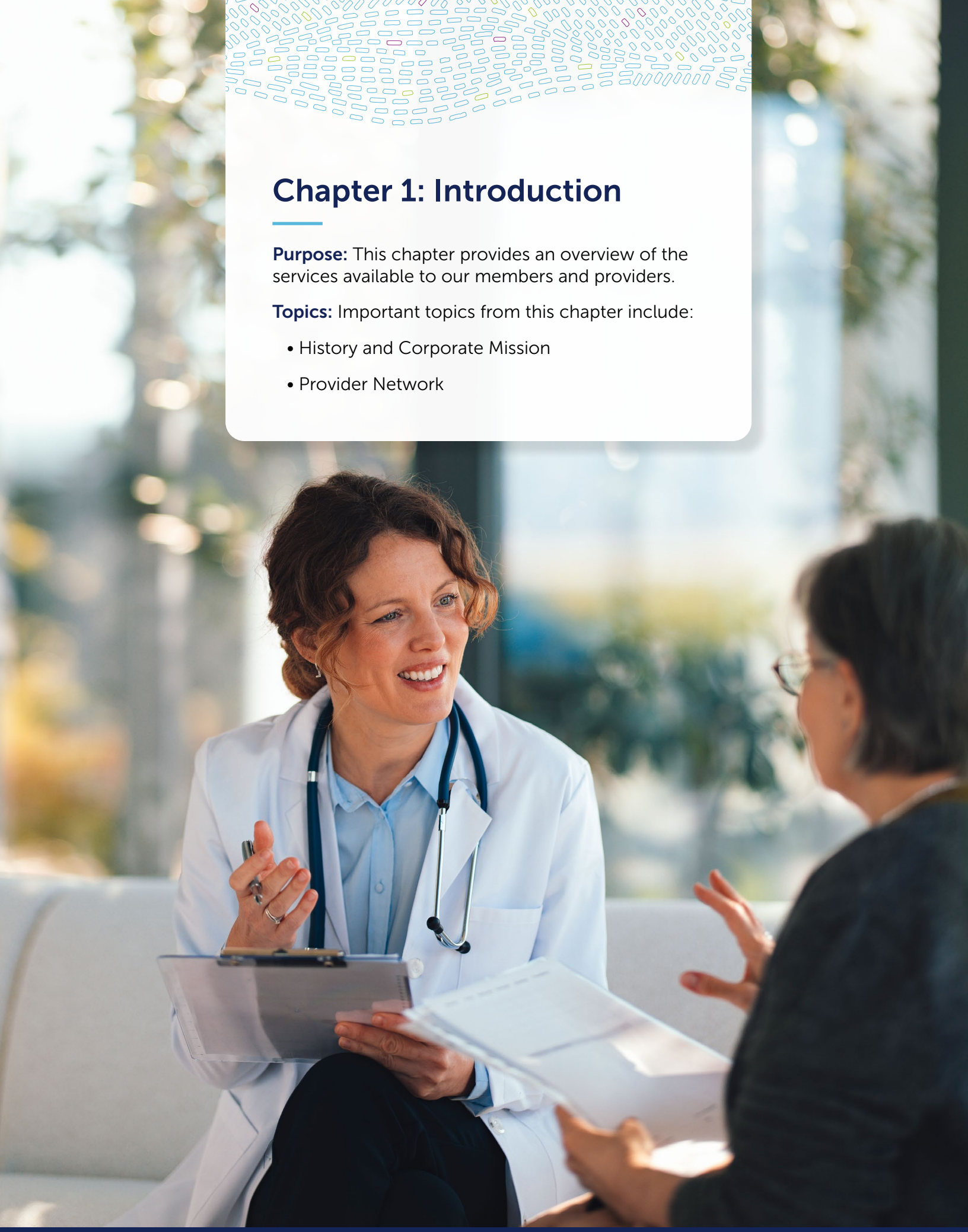
This Provider Manual is subject to change. Changes based on State or Federal requirements may be made at any time; this document is reviewed annually and is an extension of practitioner and provider contracts. This document applies to all Jefferson Health Plans' products.

# Chapter 1: Introduction

**Purpose:** This chapter provides an overview of the services available to our members and providers.

**Topics:** Important topics from this chapter include:

- History and Corporate Mission
- Provider Network



# Introduction



Health Partners Plans, Inc., is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) that provides comprehensive health care coverage to individuals and families in Pennsylvania and New Jersey. The organization was founded by several local teaching hospitals committed to providing residents of their communities with coordinated, quality health care services. With the endorsement of the Pennsylvania Department of Human Services (DHS) and a grant from the Robert Wood Johnson Foundation, under its national program for prepaid managed health care, Health Partners Plans, Inc. and its member hospitals developed a viable managed care program for the Medical Assistance population. Health Partners Plans, Inc. was incorporated in 1987. In November 2021, Thomas Jefferson University ("Jefferson") became the sole owner of Health Partners Plans, Inc. In 2023, we began using the Jefferson Health Plans marketing name for some of our Health Plan products, and by 2026, the transition was completed across all products. As part of "One Jefferson" with Thomas Jefferson University and Jefferson Health, we are a leader in innovative managed care, going beyond the basics to offer our members enhanced health and wellness benefits and a strong commitment to building healthier lives and stronger communities.

# Our Mission, Vision and Values

## Our Mission

We Improve Lives.

## Our Vision

Reimagining health, education and discovery to create unparalleled value.

## Our Values

The behaviors our employees demonstrate daily to our patients, students, health plan members, visitors and each other enable Jefferson to continue to achieve our mission. Jefferson's values guide our decisions, actions and culture. They define who we are as an organization, what we stand for and how we continue the work of improving lives that began here more than two centuries ago. These values are:

- Put People First
- Do What's Right
- Pursue Excellence

As part of our commitment to our mission, vision and values, we work to assure that providers are sensitive to cultural differences in all health care encounters.

## Our Products

We have four product lines:

- Jefferson Health Plans EverWell
- Jefferson Health Plans CHIP
- Jefferson Health Plans Medicare Advantage
- Jefferson Health Plans Individual and Family Plans



## Our Product History

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

In 2003, we sought and obtained accreditation for the first time from the National Committee for Quality Assurance (NCQA), the nation's leading review organization for health plans.

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

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

In 2013, we re-entered the Medicare Advantage program. Our first Medicare Advantage members became effective on January 1, 2014.

On January 1, 2020, our Medicare Advantage plan expanded its service area to serve residents of Berks, Bucks, Carbon, Chester, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Northampton, Perry, and Philadelphia counties. Today, our Medicare products include HMO, DSNP and PPO in Adams, Allegheny, Beaver, Berks, Bradford, Bucks, Carbon, Chester, Clarion, Crawford, Cumberland, Dauphin, Delaware, Erie, Forest, Franklin, Lancaster, Lebanon, Lehigh, Montgomery, Monroe, Northampton, Perry, Philadelphia, Schuylkill, York, Warren and Washington in Pennsylvania; and HMO, PPO in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, and Salem counties in New Jersey.

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

In 2023, we continued our growth by entering the Exchange book of business. We successfully launched the Jefferson Health Plans Individual and Family Plans in Philadelphia, Bucks and Montgomery counties. Today, our Individual and Family Plans HMO product is offered in Bucks, Carbon, Delaware, Lehigh, Monroe, Montgomery, Northampton, Philadelphia, and Schuylkill counties; and PPO products in Bucks, Delaware, Lehigh, Montgomery, Northampton and Philadelphia counties.

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

## Our Provider Network

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

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

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

## Service Departments

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

### Case Management

Our Clinical Care Management Care Coordinators who are nurses, social workers and outreach coordinators are ready to assess and address all your patient's needs including behavioral health and health-related social needs (HRSN) and connecting them to the appropriate resources. These programs are based on collaboration with providers to improve coordination of the provider's treatment plan, reduce barriers for members in following treatment recommendations, and promote self-management.

- **Clinical Care Management Provider Line Phone:** 1-215-845-4797

### Member Relations

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

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

### Provider Support Services

- **Provider Services Helpline (9 a.m. to 4:30 p.m.):** 1-888-991-9023
- **Quality Management:** 1-855-218-2314
- **SIU (Special Investigations Unit):** 1-866-477-4848
- **Skilled Nursing Facility (SNF)/Rehab:**
  **Medicaid:** 267-385-3825
  **Medicare:** 215-991-4395
  **Fax:** 215-991-4125

### Pharmacy

- **Pharmacy Department:** 1-866-841-7659
- **Fax (Medicaid):** 1-866-240-3712
- **Fax (Medicare):** 1-866-371-3239
- **Fax (Individual and Family Plans):** 1-833-605-4407

- **Recipient Restriction Program information:**
  215-991-4094
  Fax: 267-515-6651

## Utilization Management

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

Follow prompts to get to the appropriate department. Ancillary services-Medicaid and Medicare (DME, Homecare/Home infusion, Shift care, and Transportation) uses a voicemail system. We will return the voicemail within 1 business day. If it is a question regarding auth status, please use the provider portal.

Please use portal to submit prior authorization requests but if fax is required:

- **Precert fax:** 215-849-7096
- **Maternity fax:** 215-967-9245
- **Medicaid DME fax:** 215-849-4749
- **Medicaid Home care/Home infusion fax:**
  215-967-4491
- **Shift care fax:** 267-515-6667
- **Transport fax:** 267-515-6627
  (both Medicaid and Medicare)
- **Medicare DME fax:** 267-515-6636
- **Medicare Home care/Home infusion fax:**
  267-515-6633

## Credentialing

- **Status, Correspondence, Enrollment:**
  credentialing@jeffersonhealthplans.com
  Fax: 215-967-4473
- **Data changes/Terminations:**
  datavalidation@jeffersonhealthplans.com
- **Hospital/Facility Based and Physical/ Occupational/Speech Therapy Linkages, Terminations & Changes:**
  providerdata@jeffersonhealthplans.com

## Online Resources

- **Jefferson Health Plans EverWell/Jefferson Health Plans CHIP member website:**
  JeffersonHealthPlans.com
- **Jefferson Health Plans Medicare Advantage/ Jefferson Health Plans Individual and Family Plans member website:**
  JeffersonHealthPlans.com
- **Provider website for all products:**
  JeffersonHealthPlans.com/Home/Providers



# Chapter 2: Cultural Competency & Nondiscrimination

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

**Topics:** Important topics from this chapter include:

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



## Overview



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

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

## Our Nondiscrimination Policy

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

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

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

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

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

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

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

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

## Protecting Individuals Against Sex Discrimination

Sex discrimination prohibited under Section 1557 includes discrimination based on:

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

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

We expect that all contracted providers/suppliers, hereinafter referred to as "covered entities" for these purposes, will not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or gender identity.

In the event an individual with a disability needs assistance, we expect that covered entities will take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others. Covered entities are expected to provide appropriate auxiliary aids and services, such as alternative formats (e.g., large print, audio, accessible electronic formats, and other formats), sign language interpreters, etc., where necessary for effective communication.

All Health Plan staff provide free language services to people whose primary language is not English, such as qualified interpreters and materials in languages other than English. We expect that covered entities will take appropriate steps to provide meaningful access to each individual with limited English proficiency that is eligible to be served or likely to be encountered. Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translation.

We are committed to ensuring all members have access to needed health services without fear of being discriminated against.

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

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

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

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

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

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

# Cultural Competency

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

Our providers must demonstrate cultural competency and must understand that racial, ethnic, and cultural differences between a provider and a member cannot be a barrier for a member to access and receive quality health care. We encourage providers to be aware of cultural and linguistic differences among diverse racial, ethnic, and other minority groups, to be respectful of those differences and take steps to apply that knowledge in their professional practice.

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

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

To support the CLAS Standards mandate, we have included (in the Appendix) training resources on the importance of providing services in a culturally and linguistically competent manner.

## Provider Responsibilities to Address Language Needs

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

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

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

### Provider Responsibilities Include:

- Informing and providing patients with access to medical interpreters, signers, and TDD/TTY services to facilitate communication, without cost to them. This includes at all points of contact and during all hours of operation. Federal law and state contractual requirements are applicable to our Network Providers to provide language services to Limited English Proficiency (LEP) and Low Literacy Proficiency (LLP) members. This also includes members with sensory impairments.
- Providing members with verbal and written notice (in their preferred language or format) about their right to receive free language interpreters, upon request.
- Methods of meeting the language needs of patients include telephonic interpreters, video conferencing as well as in person interpreters.
- Discouraging members from using family or friends to meet language needs (translators

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

- Providing care with consideration for the member's race/ethnicity, disability, and language and how it impacts the member's health or illness.
- Offering office staff cultural competency training and development.
- Posting and the availability of printed materials in English and Spanish, and any other required non-English language upon request by the member.
- Posting the notice of nondiscrimination and the Notices of Availability in physical locations where providers interact with the public.

*Tip: Visit our Cultural Competency webpage for examples of when a qualified interpreter is required when cultural differences may interfere with the doctor/patient communication.*



## Resources Available to Providers

Call our Provider Services Helpline at 1-888-991-9023 for more information on how to find Agencies to certify your staff as interpreters, find in-office interpreter services if you currently do not have such resources, as well as a connection to telephonic language resources to meet the needs of all your patients and to ensure compliance with these regulations.

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

For more information regarding **Limited English Proficiency (LEP)**, please visit hrsa.gov.

The Office for Civil Rights (OCR) has translated a sample notice of nondiscrimination and the Notices of Availability for use by covered entities into 64 languages. For **translated materials**, visit hhs.gov/civil-rights/for-providers/index.html.

For more information regarding **Protections for Individuals with Disabilities (ADA)**, please visit hhs.gov/civil-rights/for-individuals/disability/index.html.

## Nondiscrimination Information

**Jefferson Health Plans EverWell** and **Jefferson Health Plans CHIP** nondiscrimination information can be located on our website, please visit the bottom of our Jefferson Health Plans EverWell Member Welcome webpage.

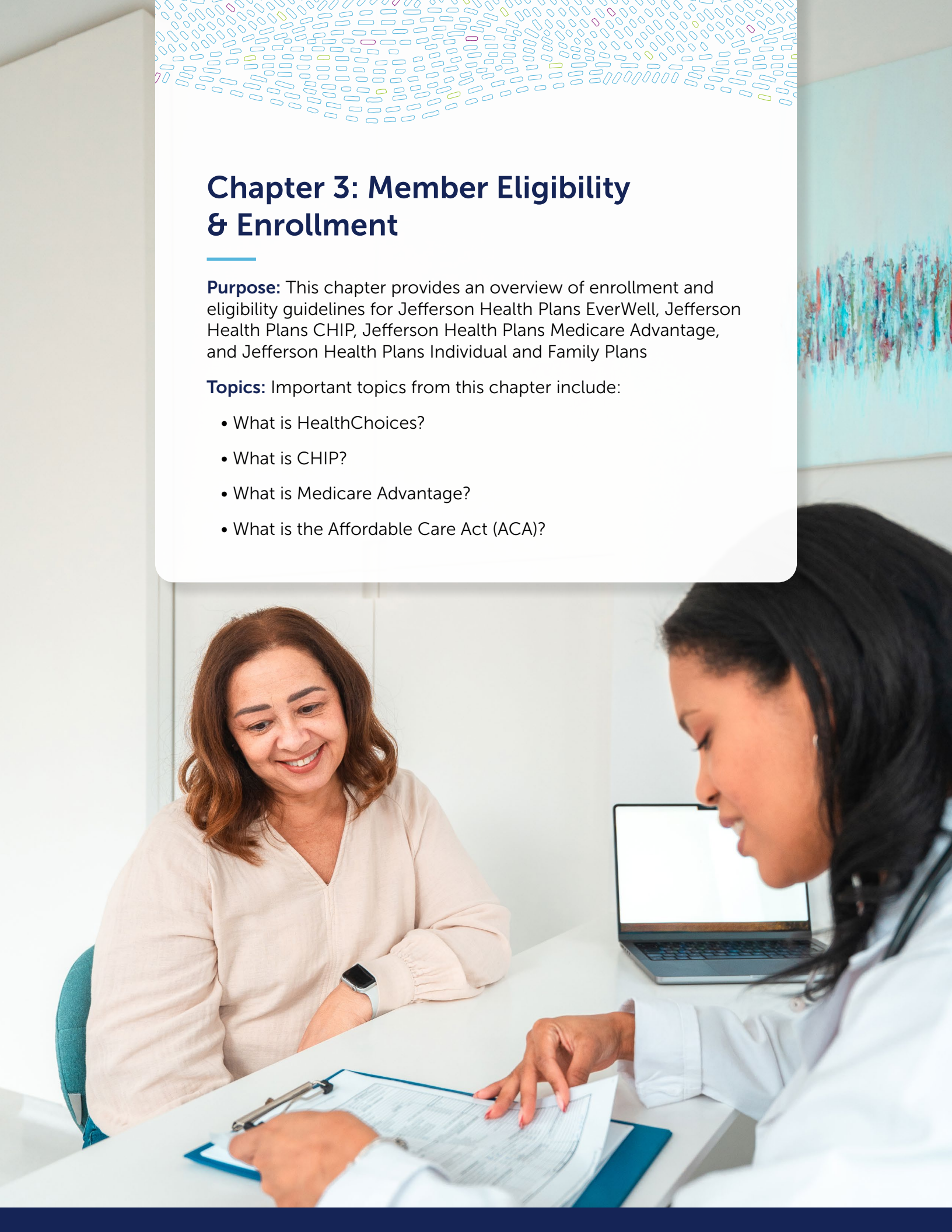
Nondiscrimination for **Jefferson Health Plans Medicare Advantage** and **Individual and Family Plans** product lines can be found on our website at Non-Discrimination Notice.

# Chapter 3: Member Eligibility & Enrollment

**Purpose:** This chapter provides an overview of enrollment and eligibility guidelines for Jefferson Health Plans EverWell, Jefferson Health Plans CHIP, Jefferson Health Plans Medicare Advantage, and Jefferson Health Plans Individual and Family Plans

**Topics:** Important topics from this chapter include:

- What is HealthChoices?
- What is CHIP?
- What is Medicare Advantage?
- What is the Affordable Care Act (ACA)?



# Overview

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

### Jefferson Health Plans CHIP

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

### Jefferson Health Plans EverWell

- **Medical Assistance:** Provides free insurance for qualifying children, teens, and adults.

### Jefferson Health Plans Medicare Advantage (HMO/PPO)

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

### Jefferson Health Plans Individual and Family Plans:

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

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

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

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

# What is HealthChoices?

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

### Enrollment

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

Once a Medical Assistance recipient has enrolled with Jefferson Health Plans, he or she may make future changes to his or her PCP directly with us.

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

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

## The Jefferson Health Plans Member ID Card

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

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

## Verification of Eligibility

Providers may verify member eligibility by:

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

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

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

## Third Party Liability

Third Party Liability (TPL) and Coordination of Benefits (COB) requirements are described in **Chapter 12**.

## Member Panels

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

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

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

## Member Transfers

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

### Voluntary Transfers

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

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

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

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

### Involuntary Transfers

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

- Member demonstrates a pattern of broken appointments without adequate notice
- Member and the provider have failed to establish an adequate patient/provider relationship
- Challenge to member selection of their PCP (Providers with panel status of existing members only)

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

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

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

## Recipient Restriction Program

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

## Loss of Medical Assistance Eligibility

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

## Care Gap Report

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

# What is CHIP?

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

## Enrollment

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

## The Jefferson Health Plans CHIP Member ID Card

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

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

## Verification of Eligibility

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

## Third Party Liability

Third Party Liability (TPL) and Coordination of Benefits (COB) requirements are described in **Chapter 12**.

## Member Panels

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

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

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

## Member Transfers

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

### Voluntary Transfers

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

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

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

### Involuntary Transfers

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

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

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

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

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

## Care Gap Report

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

# What is Medicare Advantage?

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

## The Jefferson Health Plans Medicare Advantage Member ID Card

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

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

## Verification of Eligibility

Providers may verify eligibility by:

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

## Third Party Liability

Third Party Liability (TPL) and Coordination of Benefits (COB) requirements are described in **Chapter 12**.

## Member Panels (not applicable to PPO products)

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

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

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

## Member Transfers (not applicable to PPO products)

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

### Voluntary Transfers

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

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

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

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

### Involuntary Transfers

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

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

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

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> Attn: Member Relations Department
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107

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

## Care Gap Report

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

# What is the Affordable Care Act (ACA)?

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

## The Jefferson Health Plans Individual and Family Plans Member ID Cards

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

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

## Verification of Eligibility

Providers may verify eligibility by:

- Logging on to our **Provider Portal**.
- Calling the Provider Services Helpline and providing the patient's name and birth date. Refer to **Chapter 1** for the appropriate contact information.

## Third Party Liability

Third Party Liability (TPL) and Coordination of Benefits (COB) requirements are described in **Chapter 12**.

## Member Transfers (not applicable to PPO products)

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

### Voluntary Transfers

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

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

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

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

### Involuntary Transfers

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

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

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

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

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

## Care Gap Report

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

# Chapter 4: Jefferson Health Plans EverWell Summary of Benefits

**Purpose:** This chapter provides an overview of the benefits available to Jefferson Health Plans EverWell members

**Topics:** Important topics from this chapter include:

- Summary of **Medicaid** benefits



# Overview

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

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



# Summary of Benefits

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

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

# Jefferson Health Plans EverWell Benefits

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

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Acupuncture** | Yes | 16 and older, 20 visits/calendar year | Yes | No |
| **Advanced Diagnostic Radiology (MRI, CT, PET)** | Yes | No | Yes: Contact EviCore | $0 |
| **Ambulance (Emergent)** | Yes | No | No | $0 |
| **Ambulatory Surgery Center/ Short Procedure Unit/Outpatient Surgeries** | Yes | No | No | $0 |
| **Annual Eye Exam** | Yes | 2/year | No | $0 |

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Audiology Services** | Yes | No | No | $0 |
| **Chiropractic Services** | Yes | No | Yes: Contact EviCore | $0 |
| **Clinic (Outpatient Hospital, Independent, & FQHC)** | Yes | No | No | $0 |
| **Cosmetic Services** | No | N/A | Yes: For Restorative Services | $0 |
| **Cardiac Rhythm Devices (Pacers and Defibrillators)** | Yes | No | Yes: Contact EviCore | $0 |
| **Dental (Diagnostic, preventive, restorative and surgical dental procedures, prosthodontics and sedation)** | Yes | Dentures: 1 per lifetime<br>Exams/ prophylaxis: 1 per 180 days;<br>Crowns, Periodontics and Endodontics only via approved benefit limit exception | Contact Avesis | $0 |
| **Diagnostic Cardiac Catheterizations** | Yes | No | Yes: Contact EviCore | $0 |
| **Diagnostic Radiology (X-ray)** | Yes | No | No | $0 |
| **Doulas** | Yes | Once per year | No | $0 |
| **Durable Medical Equipment Purchase** | Yes | No | Yes, >$500 | $0 |
| **Durable Medical Equipment Rental** | Yes | No | Yes | $0 |
| **Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program (Children)** | Yes | No | No | $0 |

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program (Adults)** | No | Not Covered | Not Covered | Not Covered |
| **Elective Inpatient Surgical Care** | Yes | No | Yes | $0 per day up to $0 per admission |
| **Emergency Services** | Yes | No | No | $0 |
| **Eyewear (Contact, Lenses, or Frames)** | Yes | See Vision Care for details | Yes: Contact Davis Vision | $0 |
| **Family Planning** | Yes | No | No | $0 |
| **Fitness (Gym) Membership** | Yes | Annual membership covered program requirements apply | No | $0 probationary visits |
| **Hearing Aids for Children** | Yes | N/A | Yes, >$500 | $0 |
| **Hearing Aids for Adults** | No | N/A | N/A | N/A |
| **Home Infusion** | Yes | No | Yes | $0 |
| **Home Health Nurses, Social Workers, Aids or Therapists** | Yes | No | Yes | $0 |
| **Hospice (Inpatient only)** | Yes | No | Yes: COTI, Election of Hospice Form and Plan of Treatment/Clinical Documentation | $0 |
| **Hyperbaric Oxygen Therapy** | Yes | No | Yes | $0 |
| **Infertility Treatment** | No | N/A | N/A | N/A |
| **Inpatient Acute Hospital** | Yes | No | Yes | $0 per day up to $0 per admission |
| **Inpatient Rehab Hospital** | Yes | No | Yes | $0 per day up to $0 per admission |

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (IID) and Other Related Conditions (ORC)** | Yes | ICF/IID Admission results in immediate disenrollment;<br>ICF/ORC admission requires prior auth.<br>30 days with disenrollment. | Yes | $0 |
| **Laboratory** | Yes | No | No | $0 |
| **Long Term/ Custodial Nursing Home Care** | Yes | No | Yes | $0 |
| **Medical Diagnostics** | Yes | No | No | $0 |
| **Medical Oncology (Chemotherapy)** | Yes | No | Yes: Contact EviCore | $0 |
| **Medical/Surgical Supplies** | Yes: Diabetic supplies are covered under the Rx benefit | No | Yes: >$500 | $0 |
| **NICU and/or detained newborn** | Yes | No | Yes | $0 |
| **Non-Emergent Care Outside USA** | No | N/A | N/A | N/A |
| **Non-Emergent Ambulance** | Yes | No | No | $0 |
| **Nuclear Medicine** | Yes | No | No | $0 |
| **Nutritional Supplements *Oral Supplements is not a covered benefit** | Yes | No | Yes | $0 |
| **Obstetrical Outpatient (Pre and Post-Natal)** | Yes | No | No | $0 |
| **Orthotic (Diabetics only)** | Yes | No | Yes | $0 |

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Outpatient Physical and Occupational Therapy** | Yes | No | Yes: Contact EviCore | $0 |
| **Outpatient Speech Therapy** | Yes | No | Yes: Contact EviCore | $0 |
| **PCP visits (including CRNP, PA)** | Yes | No | No | $0 |
| **Pain Management** | Yes | No | Yes: Contact EviCore | $0 |
| **Pharmaceutical** | Yes | No | Yes: If designated as prior auth. drug or non-formulary (Prescription) | $0 generic and $0 brand |
| **Podiatrist Services** | Yes | No | No | $0 |
| **Preventive Physical exam** | Yes | No | No | $0 |
| **Private Duty Nursing (21 and older)** | No | N/A | N/A | N/A |
| **Private Duty Nursing (under 21)** | Yes | No | Yes | $0 |
| **Prosthetic Device** | Yes | Hearing Aids are not covered.<br>Ocular prosthesis is limited to 1/yr.<br>Low vision aids are limited to 1/2yr. | Yes; greater than $500 | $0 |
| **Radiation Therapy** | Yes | No | Yes: Contact EviCore | $0 |
| **Renal Dialysis** | Yes | No | No | $0 |
| **Respite Care** | Yes | 5 days every 60 certified days | Yes | $0 |
| **Skilled Nursing Facility** | Yes | No | Yes | $0 |
| **Sleep Management** | Yes | No | No | $0 |

| Jefferson Health Plans EverWell Benefits | | | | |
|---|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** | **Copay** |
| **Specialist visits (including CRNP, PA)** | Yes | No | No | $0 |
| **Spine and Joint Surgeries** | Yes | No | Yes: Contact EviCore | $0 |
| **Stress Echocardiography, Echocardiography, & Cardiac Nuclear Medicine Imaging** | Yes | No | Yes: Contact EviCore | $0 |
| **Tobacco Cessation** | Yes | 70 visits per calendar year | No | $0 |
| **Transportation (van service)** | Yes | No | Yes | $0 |
| **Ultrasound (US)** | Yes | No | No | $0 |
| **Urgent Care** | Yes | No | No | $0 |
| **Vascular Surgeries** | Yes | No | Yes | $0 |

## Benefits During and After Pregnancy

Members who are confirmed to be pregnant are not subject to limitations on the number of services or copayments. Members are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy and until the end of their 12-month postpartum period. These services include expanded nutritional counseling and smoking cessation services. However, services not ordinarily covered under a pregnant member's benefit package are not covered, even while pregnant.

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



### Pregnant Members Have No Service Limitations

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

## Jefferson Health Plans EverWell Members with Medicare Coverage

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

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

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

## Abortion Services

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

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

When Part II of the MA-3 form is completed by the physician, an MA-368 form must be attached as well.

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

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

## Acupuncture

Jefferson Health Plans EverWell covers Acupuncture services. Services must be provided by a network provider specifically credentialed to perform Acupuncture. Service limits apply and prior authorization is required. Please see the **Jefferson Health Plans EverWell benefits grid** in this chapter for more information.

## Allergy Testing and Treatment

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

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

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

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

## Ambulance

Jefferson Health Plans covers all emergency ambulance services with qualified transport services. All non-emergent transportation services must be provided by a Jefferson Health Plans approved transportation service. Prior authorization is not required. Also, see Transportation (Non-Emergent).

## Ambulatory Surgical Center/Short Procedure Unit/Outpatient Surgery Services

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

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

The procedure must be performed in connection with covered services. Claims for Ambulatory Surgery and SPU procedures must be billed using the appropriate national standard for billing code type, revenue codes, procedures, and the appropriate modifier (SG) for all three services. All other procedures will be considered Outpatient Services.

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

## Blood Pressure Cuffs

Blood pressure cuffs are covered for all members, regardless of age, gender or diagnosis. Blood pressure cuffs require a provider order and must be obtained from a participating DME provider.

## Cardiac Rehabilitation

Cardiac rehabilitation services are covered when the member has a documented diagnosis of acute myocardial infarction within the preceding twelve (12) month period; had coronary bypass surgery; and/or have stable angina pectoris.

These cardiac rehabilitation services are covered only in outpatient or home settings. No prior authorization is required.

## Chiropractic Care

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

## Colorectal Screenings

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

## Community Health Workers

Community Health Worker (CHW) services that are recommended and billed for by a licensed practitioner of the healing arts enrolled in the Medical Assistance program are covered up to 3 visits per year. This includes physicians, physician assistants, certified registered nurse practitioners, and certified nurse midwives. **CHWs must be certified through the Pennsylvania Certification Board**.

## Dental

Jefferson Health Plans contracts with a dental benefits administrator/subcontractor. All members are offered dental services effective the first day of eligibility subject to their benefit package. Certain services, including all SPU services, require prior authorization by the dental benefits subcontractor. All dental procedures that require hospitalization must be prior authorized by Jefferson Health Plans' Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.

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

## Diabetes Self-Management Training and Education

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

## Diabetes Self-Management Supplies

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

## Dialysis

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

## Doula Services

Doula services are covered to include prenatal and postpartum visits, and also includes the attendance during the labor/delivery admission. Doulas must be certified through the Pennsylvania Certification Board as a Certified Doula to be covered. Doula services are limited to each pregnancy upon the member's request. Prior authorization is not required. Providers and/or members may outreach to our EMSU/Clinical Care Management – Baby team to learn more.

## Durable Medical Equipment (DME)

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

Key points to remember when prescribing DME items for Jefferson Health Plans EverWell members:

- All purchased DME items or supplies and outpatient services with a reimbursement value less than $500 per claim line **DO NOT** require prior authorization from Jefferson Health Plans.
- If any portion of a purchased customized DME device has a reimbursement value greater than $500, an authorization is required for the entire DME device.
- All DME rentals require prior authorization, regardless of reimbursement value.

When the patient is renting a DME product covered by their previous insurer, it is the DME provider's responsibility to provide Jefferson Health Plans with the following information:

- Clinical documentation
- Physician orders
- Number of months covered by the previous insurer
- Termination date of the member's previous insurance coverage

If, at the time of the member's transition, the DME rental is deemed medically necessary, Jefferson Health Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (90 days) to ensure continuity of care.

- All special items which do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.

- Prior authorization is required for more than 300 incontinence briefs, pull-ups, or diapers per month, or for any combination of two or more of these products per month.
- Authorizations are based on benefit coverage/ medical necessity.
- Preferred nebulizers and humidifiers are covered under the pharmacy benefit.

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

**Prior authorization is not required for line items with a reimbursement value less than $500.**

**Exceptions to this include:**

- Non-Covered Items
- Misc Codes (E1399, K0108, A4335, etc.)
- Exceeding quantity limits
- B Codes – formula only
- Incontinence supplies – when the request is for more than 200 units in total

**Prior Authorization is required for all Rentals regardless of reimbursement value and Purchases with a reimbursement value greater than $500.**

All prior authorization requests should be submitted to the Plan via the **Provider Portal**. Prior authorization status may also be checked via the portal.

## Home Accessibility DME

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

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

## Emergency Care

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

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

## Emergency Services

Members are instructed to go to the nearest emergency room (ER) or call 911 for emergency care. An emergency medical condition is defined by the Commonwealth's Department of Human Services as a medical condition manifesting itself by acute symptoms of sufficient severity (including

severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

## Family Planning

Family planning counseling services are covered by Jefferson Health Plans. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist, nurse midwife or a Family Planning Council site. Members have the option to self-refer to the Family Planning Council, Ob/Gyn or nurse midwife without prior approval from a PCP. Members are not required to obtain family planning services from an in-network provider.

For further information, providers can call (on behalf of their members) the Jefferson Health Plans Member Relations department. Refer to Chapter 1 for **Contact Information**.

## Foot Care

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

## Gynecological and/or Obstetric Examinations

The PCP may perform routine gynecological exams as appropriate. Members may self-refer to OB/GYN specialists or nurse midwives for any routine gynecological and/or maternity services without prior approval from a PCP. Members receiving maternity care from an Out-of-Network OB/GYN at the time of enrollment may continue to receive services from that provider throughout the pregnancy and postpartum period.

Providers are encouraged to notify Jefferson Health Plans as soon as a pregnant member is identified.

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

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

For more information, refer to Chapter 1 for **Contact Information**.

## EPSDT

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

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

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

Services not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration, or scope, may be covered under this program.

## Hearing Examinations

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

## Hearing Aids

Hearing aid services are covered for Jefferson Health Plans EverWell pediatric members up to age 21. Coverage is limited to 1 hearing aid per ear, per year. Prior authorization is required for hearing aids with a reimbursement value greater than $500. Related hearing aid services (fittings, molds, accessories [including batteries]) are covered and do not require prior authorization unless the reimbursement value is greater than $500. Hearing aids for adult members over age 21 are not covered.

## Home Health Care

Home care services are covered when medically necessary. Jefferson Health Plans can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except the initial evaluation. The initial evaluation request, along with clinical and signed practitioner orders, must be submitted for authorization within 5 days of the initial visit for reimbursement. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic/drug therapy ("Home infusions") are also covered home care benefits if they have been authorized prior to the care. Requests for enteral nutrition services must include the clinical documentation to evaluate for medical necessity.

One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 7-84 days post-delivery. Additional post-delivery home care visits will require prior authorization, and requires same submission of the required clinical documentation and plan of care as with any home health request.

## Hospice Care

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

Use the home care/hospice request form available on the form and supply page of our website. If you are in network, prior authorization is not required for Home Hospice services.

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

Medicaid will cover hospice services when:

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

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

A prior authorization is not needed for Participating providers.

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization.

Coverage under the home hospice CPT T-codes (T2024, T2403) include:

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

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

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

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

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

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

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

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

## Hospital Services

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

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

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

- Room, meals and general nursing care in a semi-private room (unless other accommodations are medically necessary)
- Physician services
- Special care units, such as intensive care or coronary care units
- Special diets, when medically necessary
- Blood transfusions and their administration
- X-ray, laboratory and other diagnostic tests
- Services and supplies furnished by the hospital for inpatient medical and surgical treatment
- Operating and recovery room
- Oxygen, medication and anesthesia
- Use of durable medical equipment (DME) such as wheelchairs
- Rehabilitation services such as physical therapy, occupational therapy and speech pathology
- Inhalation therapy, chemotherapy and radiation therapy
- Kidney, heart, heart/lung, lung, liver, bone marrow and corneal transplants for approved indications in Medicare-certified transplant facilities or transplant facilities approved by Jefferson Health Plans
- Maintenance dialysis in an approved renal dialysis facility or hospital
- Professional services will be eligible for payment when an emergent inpatient stay is downgraded or denied for level of care.
- Professional services are not eligible for payment when the planned acute inpatient denied for medical necessity.

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

Behavioral health services may include inpatient services, partial hospitalization services for mental illness, emotional disorders and alcohol and drug abuse services and are managed by the Behavioral Health Managed Care Organization (BH-MCO).

The admitting physician may request an expedited appeal with the Medical Director. Physician-to-physician discussion is always available during the review process by calling 1-866-500-4571.

The PCP (or the covering hospital physician or hospitalist) should make rounds on admitted patients regularly regardless of the provider admitting the patient. Jefferson Health Plans

will look to the PCP for assistance in ensuring appropriate utilization of hospital services.

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

## Injectables

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

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

### JW Modifier

Physicians and hospitals are required by CMS to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

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

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

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

## Laboratory

Outpatient laboratory services are provided by Quest Diagnostics, LabCorp, HNL Lab Medicine, and other hospital locations contracted for laboratory services. Locations of participating labs can be found via our **Provider Directory**. Physicians must complete the requisition form for all laboratory services. Laboratories must be CLIA-approved for participation in the Medical Assistance Program.

### Laboratory Services Performed in the Office

Providers may be reimbursed for STAT lab services performed in the office when the member has a benefit for those services, the provider is contracted to perform those services, and when billed according to Jefferson Health Plans' policy.

## Mammograms

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

## Medical Oncology Services

Medical oncology services are covered. Inpatient services require prior authorization by Jefferson Health Plans. Contact EviCore Inc., for prior authorization:

**EviCore.com/Resources/HealthPlan/Jefferson-Health-Plans.**

## Medical Supplies

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

## Medical Visits

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

## Mental Health and Substance Abuse Treatment

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

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

## Pharmacy

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

A formulary, also called statewide preferred drug list (PDL), is a list of medicines that Jefferson Health Plans covers. The statewide preferred drug list is the same for all Medicaid members across Pennsylvania. In addition to the PDL, Jefferson Health Plans also covers a supplemental formulary, which includes medications outside the scope of the PDL. The formulary has both brand name and generic drugs. Generic drugs contain the same active ingredients as brand name drugs.

Any medicine prescribed that is not on Jefferson Health Plans' formulary needs prior authorization. The formulary can change from time to time, so you should make sure that you have the latest information when prescribing a medicine.

Links to the statewide PDL, Jefferson Health Plans supplemental formulary, and drug specific prior authorization forms can be found on our **Formularies** webpage.

For additional printed copies, please call the Provider Services Helpline.

## Pharmacy Benefit Design

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

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

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

## Pharmacy Prior Authorization

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

**Home Infusion services are covered under the medical benefits.**

**Prior authorization requests for Home Infusion services must be submitted by the Home Infusion vendor directly to Jefferson Health Plans EverWell Ancillary Prior Authorization Department. Requests can be submitted via the provider portal by choosing "Drugs and Biologics" under the "Request Type" dropdown.**

**Do not choose "Outpatient". This will delay the determination.**

**If the provider portal is down, requests may be submitted by fax to 215-967-4491.**

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

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

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

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

- Specific reason for request
- Name and member number of member
- Birthdate of member
- Physician's name, license number, NPI number and specialty
- Physician's phone and fax numbers
- Name of primary care physician (PCP) if different
- Drug name, strength and quantity of medication
- Days' supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis

- Formulary medications used, duration and therapy result and documentation such as pharmacy records or chart notes
- Additional clinical information that may contribute to the review decision such as specific lab results.

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

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

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

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

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

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

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

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

Members have coverage for outpatient PT/OT/ST when performed by a participating Jefferson Health Plans provider. Prior authorization is required for all outpatient PT/OT/ST. Prior authorization is not required for outpatient evaluation. Contact EviCore Inc., for prior authorization:

**EviCore.com/Resources/HealthPlan/Jefferson-Health-Plans**.

## Preventive Health Services

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

## Prosthetics/Orthotics

Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the Jefferson Health Plans' Outpatient Services department. Orthotics and customized devices with a reimbursement value greater than $500 require prior authorization.

## Radiation Therapy

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

EviCore.com/Resources/HealthPlan/Jefferson-Health-Plans.

## Rehabilitation

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

## Shift Nursing, Personal Care and Medical Daycare

This benefit applies to Jefferson Health Plans EverWell members under age 21 who have medically complex, chronic needs and require continuous monitoring and assistance around the clock. The shift care nursing and/or home health aide can provide support for children and their families in the home setting.

Medical Daycare may be medically necessary as an alternative to in-home shift nursing or personal care services when socialization is a priority, or it is preferred by the family and BOTH of the following apply:

- Available Daycare hours and transportation arrangements can meet the family's needs, and
- Being in the Daycare presents no safety issues to the child or other daycare attendees.

Jefferson Health Plans CHIP members have a homecare benefit but are not eligible for this type of coverage. CHIP Members who require services not eligible for coverage under their benefit may request transition to Medicaid. Our Clinical Care Management team can assist in coordinating a request for transition to Medicaid.

*Members aged 21 and older do not have this shift care benefit. As members "age-out" of coverage for shift care benefits, the provider should coordinate with our Clinical Care Management team for possible coverage under a Pennsylvania Medicaid Waiver Program.

In general, each request for shift care (nursing or home health aide) or medical daycare is reviewed and a determination of the number of hours that are medically necessary is based on the unique medical needs of the child, caregivers available to help with the child's care, the caregiver capabilities, and obligations, as well as hours of school, school transportation, and school-related activities. Individual cases vary substantially based on each unique circumstance.

Prior authorization requests can be submitted via provider portal or if portal is down, fax to 267-515-6667. Use the Shift Care Authorization Form found in the provider portal.

Supporting documentation needed but not limited to:

- Letter of medical necessity (LOMN) signed and dated by certifying practitioners (NP, PA, DO, MD)
- Specific number of hours per day/week/ duration
- Work verification if hours are being requested for the legally responsible relative to attend work
- Recent office visit notes within the last 6 months
- Proof of Home Health Aide (HHA) certification if parent/legal guardian requesting to be the home health aide
- If member has autism, a copy of the member's autism diagnostic report or recent developmental pediatrics' note
- For work verification, add a LOMN from physician if parent is disabled (if reason why shift care services are being requested)

All above documents must be up to date and submitted with all requests, initial and re-authorizations

## Sigmoidoscopy

Please see alphabetized listing under "Colorectal Cancer Screening."

## Skilled Nursing Facility

Services for inpatient care in a Jefferson Health Plans participating skilled nursing facility must be prior authorized by Jefferson Health Plans' Inpatient Services department.

## Smoking Cessation

Various smoking cessation services are available to our members to assist them in quitting smoking. For more information, visit our Smoking Cessation webpage.

## Specialist Visits

Primary Care Physician (PCP) referrals to Jefferson Health Plans participating specialists and other providers are not required. Services provided by non- participating physicians and other non-participating licensed allied health personnel will be covered only when prior authorized by Jefferson Health Plans.

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

## Specialty Medication Program

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

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

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

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

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

## Sterilization

Such sterilization procedures as tubal ligation and vasectomy are covered with no prior authorization required when provided as outpatient services to Jefferson Health Plans members age 21 or older. Prior authorization is required if these services are provided on an inpatient basis. A properly completed MA-31 form documenting the member's voluntary informed consent must accompany the provider's claim for payment for all sterilization services.

Hysterectomy is not covered if solely for sterilization purposes.

## Transportation (Non-Emergent)

Non-emergent transportation services does not require prior authorization for Jefferson Health Plans EverWell members.

Jefferson Health Plans EverWell members are eligible for registration with the DHS Medical Assistance Transportation Program (MATP). More information is available at **matp.pa.gov/**. MATP can provide help with health-related transportation, including to and from doctor visits. To facilitate the process, members and providers must be registered with their respective county's MATP provider. MATP will determine transport eligibility (reimbursement, paratransit, or mass transit) based on the medical assessment supplied by the provider. Members can call their county's MATP provider to arrange transportation or call our Member Relations Department. Providers may arrange transportation by calling Clinical Case Management. For more information, refer to **Chapter 1** for **Contact Information**.

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

## Vaccines for Children (VFC) program

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

Providers in Philadelphia County must obtain their vaccine through the Philadelphia VFC program at: **vaccines.phila.gov/index.php/clinic-enrollment/**.

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

For more information, please view Jefferson Health Plans' Vaccine Coding and Reimbursement policy on our **Policy Bulletin Library** webpage.

## Vision Care

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

Davis Vision covers routine eye examinations for all members.

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

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

### Value Added Benefits

#### Fitness Program

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

## Non-Covered Services

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

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

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

## Recipient Restriction Program

Jefferson Health Plans participates in the Pennsylvania Department of Human Services Recipient Restriction Program. The program calls for Jefferson Health Plans to monitor and identify Medical Assistance recipients who improperly or excessively utilize Medicaid services. In cooperation with the Department of Human Services' Bureau of Program Integrity, Jefferson Health Plans will refer members with suspected patterns of inappropriate utilization to the Pennsylvania Department of Human Services' Recipient Restriction Program. These members may be restricted to a certain physician and/or pharmacy. Providers requesting information on this program may contact the Jefferson Health Plans Pharmacy department at 215-991-4094.

# Chapter 5: Jefferson Health Plans Medicare Advantage Summary of Benefits

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

**Topics:** Important topics from this chapter include:

- Summary of **Medicare Advantage** Benefits

| Geo | Plan Name |
|---|---|
| **PA** | Jefferson Health Plans Medicare Complete (HMO) |
| **PA** | Jefferson Health Plans Medicare Prime (HMO) |
| **PA** | Jefferson Health Plans Medicare Giveback (HMO) |
| **PA** | Jefferson Health Plans Flex (PPO) |
| **PA** | Jefferson Health Plans Flex Plus (PPO) |
| **PA** | Jefferson Health Plans Flex Pro (PPO) |
| **NJ** | Jefferson Health Plans Medicare Silver (HMO) |
| **NJ** | Jefferson Health Plans Medicare Platinum (HMO) |
| **NJ** | Jefferson Health Plans Choice (PPO) |
| **NJ** | Jefferson Health Plans Choice Plus (PPO) |
| **PA** | Jefferson Health Plans Special (HMO) D-SNP |
| **PA** | Jefferson Health Plans Dual Pearl (HMO) D-SNP |

# Overview

This chapter provides an overview of the 2026 benefits that Jefferson Health Plans members are entitled to and guidelines for appropriately utilizing authorizations.

## Regulatory Compliance

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

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

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



# Summary of Benefits

## Jefferson Health Plans Medicare Advantage

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

**A full description of all plan benefits can be found at JeffersonHealthPlans.com.**

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

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

**Jefferson Health Plans does not require PCP referrals for plan specialists.**

Prior authorization is **always required** for out-of-network services for our HMO plans, except emergency care and (for dual eligible members only) family planning and maternity care.

Prior authorization is not required for out-of-network urgent care or dialysis services when the member is temporarily out of the Jefferson Health Plans service area. Prior authorization is not required for certain services out-of-network for PPO plans (available January 1, 2024). Please go to JeffersonHealthPlans.com for details.

# Benefits Administrators/ Subcontractors

## Behavioral Health Services

Jefferson Health Plans Medicare Advantage contracts with Optum Behavioral Health, a Behavioral Health administrator/subcontractor to administer our Behavioral Health Services.

> Members may contact Optum at 1-800-424-3704 for assistance with utilizing this benefit.

## Dental

Jefferson Health Plans Medicare Advantage contracts with Avesis, a dental benefits administrator/subcontractor to administer our Dental benefits.

> Members may contact Avesis at 1-855-536-7764 for assistance with utilizing this benefit.

## Hearing Care Services

Jefferson Health Plans Medicare Advantage contracts with NationsHearing®, a hearing care administrator/subcontractor to administer our hearing care benefits.

> Members may contact NationsHearing® at 1-866-901-8000 (TTY: 1-877-454-8477) for assistance with utilizing this benefit.

## Vision Care

Jefferson Health Plans Medicare Advantage contracts with Davis Vision, a dental benefits administrator/subcontractor to administer our vision care benefits.

> Members may contact Davis Vision at 1-800-999-5431 for assistance with utilizing this benefit.

**For a full description of the benefits listed, visit JeffersonHealthPlans.com.**

# Cost-Sharing for Dual Eligible Members

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

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

### Reminder Related to Dual Eligible Billing

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

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

### Hospice Care

Jefferson Health Plans will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in Jefferson Health Plans Medicare Advantage even though they have elected hospice coverage.

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

### JW Modifier

Physicians and hospitals are required to use the JW modifier to identify discarded drugs and biologicals. The JW modifier is used to report a discarded/unused portion of a drug.

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

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

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

## Non-Covered Services

The following services and benefits are excluded or limited under Jefferson Health Plans Medicare Advantage.

- Services considered not reasonable and necessary, according to the standards of original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in the room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in-home.

- Custodial care, including care provided in a nursing home, hospice, or other facility setting when skilled medical care or skilled nursing care is not required. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with bathing, dressing or other activities of daily living.
- Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.
- Fees charged by an immediate relative or members of the member's household.
- Meals delivered to the member's home (except as provided by the meals benefit in certain plans).
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless needed due to an injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care except as shown in plan Evidence of Coverage documents. Non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines, and services shown in plan Evidence of Coverage documents.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids or exams to fit hearing aids beyond the services shown in plan Evidence of Coverage documents.
- Eyeglasses beyond the coverage shown in plan Evidence of Coverage documents. (However, eyeglasses are covered for people after cataract surgery.) Radial keratotomy, LASIK surgery, vision therapy and other low vision aids are not covered.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Drugs used to treat anorexia, weight loss, or weight gain, even if used for a non-cosmetic purpose (e.g., morbid obesity).
- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or hair growth.
- Drugs used to treat symptomatic relief of cough and colds, including over the counter (OTC) medications, except as covered by the OTC benefit in our plans.
- Prescription vitamin and mineral products, except prenatal vitamins, fluoride preparations, and as covered by the OTC benefit in our plans.

- Covered outpatient drugs which the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- Agents used to treat sexual or erectile dysfunction except when prescribed to treat medically accepted indications other than sexual dysfunction or erectile dysfunction.
- Non-prescription drugs, such as over the counter (OTC) products, except items used in the administration of insulin and those items covered by the OTC benefit in our plans.
- Home Modification under the DME Benefit is not covered, however home modification evaluation may be part of the home occupational therapy evaluation.

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

# Chapter 6: Jefferson Health Plans CHIP Summary of Benefits

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

**Topics:** Important topics from this chapter include:

- Summary of **Jefferson Health Plans CHIP** benefits
- Covered Services
- Non-Covered Services



# Overview

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



# Summary of Benefits

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

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

# Jefferson Health Plans CHIP Benefits

The following table lists the benefits available to Jefferson Health Plans CHIP members and any prior authorization, or benefit limit requirements associated with those services.

| Jefferson Health Plans CHIP Benefits | | | |
|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** |
| **Acupuncture** | Yes | Age 16 and older, 20 visits/ calendar year | Yes |
| **Advanced Diagnostic Radiology (MRI, CT, PET)** | Yes | No | Yes: Contact EviCore |
| **Ambulance (Emergent)** | Yes | No | No |
| **Ambulatory Surgery Center/ Short Procedure Unit/ Outpatient Surgeries (POS 22, 24/Rev codes 360, 490)** | Yes | No | No |
| **Annual Eye Exam** | Yes | 1/year | No |

| Jefferson Health Plans CHIP Benefits | | | |
|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** |
| **Audiology Services** | Yes | No | No |
| **Autism Services** | Yes | No | No |
| **Bariatric Surgery** | No | No | No |
| **Chemotherapy** | Yes | No | Yes: Contact EviCore |
| **Chiropractic Services** | Yes | 20 visits/year | No |
| **Clinic (Outpatient Hospital, Independent & FQHC)** | Yes | No | No |
| **Cosmetic Services** | No | N/A | Yes |
| **Diagnostic Radiology (X-ray, US)** | Yes | No | No |
| **Dental Services** | Yes | See **Dental** section | Contact Avesis |
| **Durable Medical Equipment Purchase > $500** | Yes | No | Yes |
| **Durable Medical Equipment Rental** | Yes | No | Yes |
| **Elective Inpatient Surgical Care** | Yes | No | Yes |
| **Emergency Services** | Yes | No | No |
| **Eyewear (Contact, Lenses, or Frames)** | Yes | See **Vision Care** section | No: Contact Davis Vision |
| **Family Planning** | Yes | No | No |
| **Fitness (Gym) Membership** | Yes | Annual membership covered. Program requirements apply | No |
| **Hearing Aids** | Yes | 1 hearing aid per ear every two years | Yes |
| **Home Infusion** | Yes | No | Yes |
| **Home Health Nurses, Social Workers, Aids, and Therapists** | Yes | No | Yes |

| Jefferson Health Plans CHIP Benefits | | | |
|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** |
| **Hospice (Inpatient only)** | Yes | No | No: Certification of Terminal Illness, Election of Hospice Form and Plan of Treatment/ Clinical Documentation |
| **Infertility Treatment** | No | N/A | N/A |
| **Inpatient Acute Hospital** | Yes | No | Yes |
| **Laboratory** | Yes | No | No |
| **Medical Diagnostics** | Yes | No | No |
| **Medical/Surgical Supplies** | Yes (Diabetic supplies are covered under the RX benefit) | No | Yes (If >$500) |
| **NICU and/or detained newborn** | Yes | No | Yes |
| **Non-Emergent Care Outside USA** | No | N/A | N/A |
| **Non-Emergent Ambulance** | Yes | No | Yes |
| **Nuclear Medicine** | Yes | No | No |
| **Nutritional Supplements *Oral Supplements is not a covered benefit** | Yes | No | Yes (If >$500) |
| **Obstetrical – Outpatient (Pre and Post-Natal)** | Yes | No | No |
| **Orthotic (Diabetics only)** | Yes | No | Yes (If >$500) |
| **Outpatient Physical, Occupational, and Speech Therapy** | Yes | 30 visits/year for each type of therapy | No |
| **PCP Visits (including CRNP, PA)** | Yes | No | No |
| **Pharmaceutical** | Yes | No | Yes (If designated as prior authorization drug or non-formulary prescription) |

| Jefferson Health Plans CHIP Benefits | | | |
|---|---|---|---|
| **Benefit/Service** | **Covered** | **Benefit Limit** | **Prior Authorization** |
| **Podiatrist Services (Routine)** | No | N/A | N/A |
| **Preventive Physical Exam** | Yes | No | No |
| **Private Duty Nursing (Inpatient) *In home Private duty nursing (Shift care services) and Medical Daycare are not a covered benefit.** | No | No | N/A |
| **Sleep Management** | Yes | No | No |

## Copays for Jefferson Health Plans CHIP Members

Jefferson Health Plans CHIP members may be responsible for copayments. This information is distributed to members through their Member Handbook on the Jefferson Health Plans CHIP section of our website, JeffersonHealthPlans.com, and key copay information is printed on their member ID card.

### All members enrolled in Jefferson Health Plans CHIP:

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

### Members enrolled in "free" Jefferson Health Plans CHIP:

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

### Members enrolled in "low-cost" Jefferson Health Plans CHIP pay the following CHIP copays:

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

The annual maximum out of pocket for copays is five percent of the family's income.

### Members enrolled in "full-cost" Jefferson Health Plans CHIP pay the following CHIP copays:

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

# Covered Services

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

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

## Abortion Services

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

## Acupuncture

Jefferson Health Plans CHIP covers acupuncture services. Services must be provided by a network provider specifically credentialed to perform acupuncture. Service limits apply and prior authorization is required. Please see the Jefferson Health Plans CHIP benefits grid in this chapter for more information.

## Ambulance

Jefferson Health Plans CHIP covers all emergency ambulance services with qualified transport services. All non-emergent transportation services are not covered.

## Ambulatory Surgical Center/Short Procedure Unit/Outpatient Surgery Services

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

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

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

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

## Asthma Checkups

Please refer any Member with asthma to our Member Relations team at 1-888-888-1211 (TTY 1-877-454-8477) for information on Jefferson Health Plans CHIP's Asthma Management program.

## Chemotherapy

Chemotherapy treatment is a covered benefit for Jefferson Health Plans CHIP members.



## Child Visits

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

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

## Chiropractic Care

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

## Clinical Trials

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

We must be notified in advance of the member's participation in the qualifying clinical trial.

## Covered Preventive Medications

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription. If you or the member have questions about whether a preventive medication is covered, call Member Services at 1-888-888-1211 (TTY 1-877-454-8477).

## Dental

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

- Diagnostic and Treatment Services
- Preventive Services
- Palliative Treatment of Dental Pain
- Minor Restorative Services
- Endodontic Services
- Periodontal Services
- Prosthodontic Services
- Major Restorative Services

Certain services, including all endodontic, prosthodontic, orthodontic, SPU and non-emergent oral and maxillofacial surgical services, require prior authorization by the dental benefits subcontractor. All dental procedure(s) that require hospitalization must be prior authorized by our Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.

Members can receive dental services from a participating primary care dentist. All they have to do is choose a dentist from the list of dentists in the online Jefferson Health Plans CHIP Provider

Directory. Prior authorization is not required to be seen by dental specialists, however the primary care dentist will coordinate members to dental specialists according to the policies defined by the dental subcontractor and approved by us.

## Diabetes Self-Management Training and Education

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

## Diabetes Self-Management Supplies

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

## Dialysis

Hemodialysis and peritoneal dialysis are covered benefits. Members requiring these services should be directed to a participating specialist. Most dialysis patients are eligible for Medicare benefits. In this case, Jefferson Health Plans CHIP becomes secondary insurance. Dialysis services do not need prior authorization.

Please remember to submit a 2728-U form for members with end-stage renal disease (ERSD). If a 2728-U form is not filed, Jefferson Health Plans CHIP's Enrollment department will contact the dialysis center and request a copy.

## Durable Medical Equipment (DME)

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

**Key points to remember when prescribing DME items for Jefferson Health Plans CHIP members:**

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

If, at time of the member's transition, the DME rental is deemed medically necessary, Jefferson Health Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (60 days) to ensure continuity of care.

- All special items that do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Authorizations are based on benefit coverage/ medical necessity as defined in **Chapter 8**, **Utilization Management** of this manual.

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

## Emergency Care

Emergency care and post-stabilization services in emergency rooms and emergency admissions are covered by Jefferson Health Plans CHIP for both participating and non-participating facilities, with no distinction for in- or out-of-area services. Copays may apply. Emergency care and post-stabilization services do not require prior authorization.

Non-participating follow-up care for an emergency is covered by Jefferson Health Plans CHIP, but plan staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible.

## Emergency Services (Act 68)

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

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

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

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

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

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

## Family Planning

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

## Fitness Program Membership

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

## Foot Care

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

## Gynecological and/or Obstetric Examinations

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

- Providers can call our Baby Partners unit to advise us of a pregnant member and/or members who are at risk of poor birth outcomes during business hours or our 24-hour Member Relations line to arrange to have their care coordinated by our Clinical Care Management team.
- Pennsylvania's Medical Assistance Program (Medicaid) requires all Obstetrical Needs Assessment Forms (ONAFs) to be submitted electronically online via Optum's portal at **obcare.optum.com**.

## Hearing Care Services

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

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

## Home Health Care

Home Care services are covered when medically necessary. Jefferson Health Plans CHIP can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except for the initial evaluation. The initial evaluation request, along with clinical and signed practitioner orders, must be submitted for authorization within 5 days of the initial visit for reimbursement. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic/drug therapy are also covered home care benefits if they have been authorized prior to the care. Requests for enteral nutrition services must include the clinical documentation to evaluate for medical necessity.

One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 21-56 days post-delivery. Additional post-delivery home care visits will require prior authorization.

## Hospice Care

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

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

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

Jefferson Health Plans CHIP will cover hospice services when:

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

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

A prior authorization is not needed for participating providers.

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization.

Coverage under the home hospice CPT T-codes (T2024, T2403) includes:

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

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

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

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

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

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

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

- MANNA services are separately reimbursed and do not require the -GW modifier for reimbursement.

## Hospital Services

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

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

After the effective date of coverage, medically necessary care will be provided until discharge including:

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

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

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

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

## Immunizations

All child immunizations are a covered benefit under the Jefferson Health Plans CHIP Preventive/ Well-Child Care benefit.

## Immunizations and Screenings

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control (CDC), U.S. Department of Health and Human Services. Pediatric and Adult Immunization ACIP schedules may be found by accessing **cdc.gov/vaccines/**.
- Influenza Vaccines can be administered by a participating pharmacy for members starting at the age of nine years old, with parental consent, according to PA Act 8 of 2015.
- **Health education:** A child's PCP will provide information and advice on important health issues, including prevention/cessation of all types of tobacco use, and healthy eating habits.
- **Developmental screening:** Checkups by a child's PCP will include screenings to check that children's physical and learning development are on track.
- **Allergy diagnosis and treatment:** For children exhibiting symptoms of possible allergies, preventive care includes diagnosis and treatment.
- **BMI:** Body Mass Index (BMI) may help you determine whether the member is at risk for obesity.
- **Young women's health screens:** As your members become young women, routine women's health care should include checkups, Pap tests and breast exams.

## Injectables

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

### JW Modifier

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

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

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

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

## Laboratory

Outpatient laboratory services are provided by Quest Diagnostics, LabCorp, HNL Lab Medicine, and other hospital locations contracted for laboratory services. Locations of participating labs can be found via our online **provider directory**. Physicians must complete the requisition form for laboratory services. Laboratories must be CLIA-approved for participation in the Medical Assistance Program.

## Mammograms

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

## Maternity Care

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

Through our Baby Partners program, Jefferson Health Plans CHIP provides all pregnant moms with important information about prenatal dental care (e.g., moms who take good care of their teeth have healthier babies). Dental insurance covers routine prophylaxis (including cleaning, scaling and polishing of teeth) once every 6 months, with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy.

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

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

Only one application needs to be completed to apply for both programs.

## Maternity Services

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

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

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

## Medical Supplies

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

## Medical Visits

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

## Member Education Classes

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

## Mental Health and Substance Abuse Treatment

Mental Health and Substance abuse services are provided through a subcontractor, Optum Behavioral Health. There are no limits or copays for these services. All services other than emergency must be authorized by Optum Behavioral Health. Members should call 1-800-424-3701 to obtain mental health or substance abuse services.

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

## Newborn Care

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

## Orthodontics

Jefferson Health Plans CHIP offers comprehensive orthodontic treatment and other orthodontic services provided by the CHIP program. Services must be medically necessary and require prior authorization.

Braces for cosmetic reasons are not covered.

## Pediatric Preventive Care

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

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

## Pharmacy

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

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

For additional printed copies, please call Jefferson Health Plans.

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

The Jefferson Health Plans CHIP pharmacy benefit design features:

- No prescription limits for any group.
- Over-the-Counter (OTC) medications are covered. Specific covered agents are listed in the formulary.
- All groups have the same formulary and benefit design but may differ in copayment amounts.
- Copayments do not apply to specialty medications, diabetic supplies including test strips, glucose meters and lancets.
- Preferred diabetic supplies including test strips, glucose meters, lancets, syringes and insulin are covered and processed under the pharmacy benefit according to the formulary.
- Specialty medications are covered and processed under the pharmacy benefit with prior authorization, if applicable. The specialty vendor will be utilized for these services unless prior approval has been provided by the Pharmacy department. Please refer to the **Formularies** webpage for more information and specific drug coverage.

## Pharmacy Copay Design

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

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

The formulary covers preferred, medically necessary prescription products.

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

## Pharmacy Prior Authorization

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

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

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

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

**Prior authorization requests for Home Infusion services must be submitted by the Home Infusion vendor directly to Jefferson Health Plans Ancillary Prior Authorization Department. Requests can be submitted via the provider portal or if portal is down by fax to 215-967-4491.**

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

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

- Route of administration
- Diagnosis
- Formulary medications used, duration and therapy result, and documentation such as pharmacy records or chart notes
- Additional clinical information that may contribute to the review decision such as specific lab results

All forms should be legible and completely filled out. All prior authorization forms are available on the **Prior Authorizations** page of our website.

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

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

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

- If the recipient is in immediate need of the medication in the professional judgment of the pharmacist and if the prescription is for a new medication (one that the recipient has not taken before or that is taken for an acute condition), the plan will allow the pharmacy to dispense a 5-day supply of the medication to afford the recipient or pharmacy the opportunity to initiate the request for prior authorization.
- If the prescription is for an ongoing medication (one that is continuously prescribed for the treatment of an illness or condition that is chronic in nature in which there has not been a break in treatment for greater than 30 days), the plan will allow the pharmacy to dispense a 15-day supply of the medication automatically, unless the plan mailed to the member, with a copy to the prescriber, an advanced written notice of the reduction or termination of the medication at least 10 days prior to the end of the period for which the medication was previously authorized.

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

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

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

Members may be referred for outpatient PT/OT/ST to a participating Jefferson Health Plans CHIP provider. Prior authorization is not required for participating providers. This benefit covers up to 30 visits per year for each type of therapy.

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

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

## Preventive "Well Child" Services

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

Our Pediatric and Adolescent Screening Schedule, and Pediatric Immunization Schedule are designed to assist PCPs in delivering services. For more information, visit our **Care Guidelines** webpage. PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by the plan. Please recognize that CHIP may cover services that are not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration or scope. Contact the plan for further information.

## Primary and Preventive Health Services

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

## Prosthetics/Orthotics

Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the plan's Inpatient or Outpatient Services department for any devices/supplies with a reimbursement value greater than $500.

## Radiation Therapy

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

**EviCore.com/Resources/HealthPlan/Jefferson-Health-Plans**.

## Reconstructive Surgery

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

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

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy; and
- Physical complications of all stages of mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

## Rehabilitation

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

## Skilled Nursing Facility

Inpatient care in a Skilled Nursing Facility (SNF) is covered in a Jefferson Health Plans CHIP participating skilled nursing facility. Services must be prior authorized by the plan's Inpatient Services department. Medically necessary skilled nursing and related services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital.

## Smoking Cessation

Various smoking cessation services are available to our members to assist them in quitting smoking. Smoking cessation programs generally include scheduled activities and meetings designed to help participants stop the habit of smoking. These programs are a covered benefit for Jefferson Health Plans CHIP members and do not require prior authorization from the member's PCP. For more information, visit our **Smoking Cessation** webpage.

## Specialist Visits

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

## Specialty Medication Program

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

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

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

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

Certain specialty medications are processed through the Pharmacy department and require prior authorization. Please refer to the formulary and the Pharmacy section of the **Prior Authorizations** page of our website for more information regarding specialty medications, drug specific prior authorization forms, and preferred vendors.

## Suturing

PCPs are reimbursed fees for suturing performed in their offices.

## Transportation (Non-Emergent)

Non-emergent transportation services are not covered.

## Vision Care

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

Visits for routine eye exams and glasses or medically necessary contacts are covered. A participating vision provider must be used. There are no copayments for routine eye examinations.*

*If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus or aphakia, then a copayment may apply.

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

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

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

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

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

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

All lenses include scratch resistant coating.

There may be copayments for optional lens types and treatments:

**Ultraviolet Protective Coating** ..... **$15**

**Polycarbonate Lenses** ..... **$35**
(if not child, monocular or prescription >+/-6.00 diopters)

**Blended Segment Lenses** ..... **$20**

**Intermediate Vision Lenses** ..... **$30**

**Standard Progressives** ..... **$65**

**Premium Progressives** ..... **$105**
(Varilux®, etc.)

**Photochromic Glass Lenses** ..... **$20**

**Plastic Photosensitive Lense** ..... **$65**
(Transitions®)

**Polarized Lenses** ..... **$75**

**Standard Anti-Reflective (AR) Coating** ..... **$40**

**Premium AR Coating** ..... **$55**

**Ultra AR Coating** ..... **$69**

**Hi-Index Lenses** ..... **$60**

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

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

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

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

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

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

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

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

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

Jefferson Health Plans CHIP covers routine vision exams. (Treatment of other eye problems may be covered as a medical benefit. The member's PCP can refer to an eye specialist if necessary.)

Member's can check our Jefferson Health Plans CHIP Provider Directory or call Member Relations at 1-888-888-1211 (TTY 1-877-454-8477) for help finding a convenient vision care provider.

When making an appointment, members should tell the office they are members of Jefferson Health Plans CHIP and bring their membership ID cards to the appointment.

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

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

## Well Woman Preventive Care

There is no cost sharing for preventive services under the services of family planning, women's health, and contraceptives.

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

- **Routine Gynecological Exam, Pap Smear:** Female Members are covered for one (1) routine gynecological exam each year. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician referral needed.
- **Mammograms:** Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.

- **Breastfeeding:** Comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing members at no cost share to the member.
- **Contraception:** FDA-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.
- **Osteoporosis Screening (Bone Mineral Density Testing or BMDT):** Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items.

## Non-Covered Services

The following services and benefits are excluded or limited under the Jefferson Health Plans CHIP plan:

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

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

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

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

**Topics:** Important topics from this chapter include:

- Summary of **Individual and Family Plans** benefits
- Prior Authorization Requirements
- Preventive Benefit Schedule



# Overview

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

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



# Summary of Benefits

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

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

# Jefferson Health Plans Individual and Family Plans

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

| QHP ID | Plan Name |
|---|---|
| **93909PA0010001-00** | Jefferson Health Plans + $0 Deductible + Bronze + HMO + Off Exchange |
| **93909PA0010001-01** | Jefferson Health Plans + $0 Deductible + Bronze + HMO + On Exchange |
| **93909PA0010001-02** | Jefferson Health Plans + $0 Deductible + Bronze + HMO + No Cost Sharing |
| **93909PA0010001-03** | Jefferson Health Plans + $0 Deductible + Bronze + HMO + Limited Cost Sharing |
| **93909PA0010002-00** | Jefferson Health Plans + Total + Bronze + HMO + Off Exchange |
| **93909PA0010002-01** | Jefferson Health Plans + Total + Bronze + HMO + On Exchange |
| **93909PA0010002-02** | Jefferson Health Plans + Total + Bronze + HMO + No Cost Sharing |
| **93909PA0010002-03** | Jefferson Health Plans + Total + Bronze + HMO + Limited Cost Sharing |
| **93909PA0010003-00** | Jefferson Health Plans + $0 Deductible + Silver + HMO + Off Exchange |
| **93909PA0010003-01** | Jefferson Health Plans + $0 Deductible + Silver + HMO + On Exchange |
| **93909PA0010003-02** | Jefferson Health Plans + $0 Deductible + Silver + HMO + No Cost Sharing |
| **93909PA0010003-03** | Jefferson Health Plans + $0 Deductible + Silver + HMO + Limited Cost Sharing |
| **93909PA0010003-04** | Jefferson Health Plans + $0 Deductible + Silver + HMO + 73% |
| **93909PA0010003-05** | Jefferson Health Plans + $0 Deductible + Silver + HMO + 87% |

| QHP ID | Plan Name |
|---|---|
| 93909PA0010003-06 | Jefferson Health Plans + $0 Deductible + Silver + HMO + 94% |
| 93909PA0010004-00 | Jefferson Health Plans + Balanced + Silver + HMO + Off Exchange |
| 93909PA0010004-01 | Jefferson Health Plans + Balanced + Silver + HMO + On Exchange |
| 93909PA0010004-02 | Jefferson Health Plans + Balanced + Silver + HMO + No Cost Sharing |
| 93909PA0010004-03 | Jefferson Health Plans + Balanced + Silver + HMO + Limited Cost Sharing |
| 93909PA0010004-04 | Jefferson Health Plans + Balanced + Silver + HMO + 73% |
| 93909PA0010004-05 | Jefferson Health Plans + Balanced + Silver + HMO + 87% |
| 93909PA0010004-06 | Jefferson Health Plans + Balanced + Silver + HMO + 94% |
| 93909PA0010005-00 | Jefferson Health Plans + Total + Silver + HMO + Off Exchange |
| 93909PA0010005-01 | Jefferson Health Plans + Total + Silver + HMO + On Exchange |
| 93909PA0010005-02 | Jefferson Health Plans + Total + Silver + HMO + No Cost Sharing |
| 93909PA0010005-03 | Jefferson Health Plans + Total + Silver + HMO + Limited Cost Sharing |
| 93909PA0010005-04 | Jefferson Health Plans + Total + Silver + HMO + 73% |
| 93909PA0010005-05 | Jefferson Health Plans + Total + Silver + HMO + 87% |
| 93909PA0010005-06 | Jefferson Health Plans + Total + Silver + HMO + 94% |
| 93909PA0010006-00 | Jefferson Health Plans + $0 Deductible + Gold + HMO + Off Exchange |
| 93909PA0010006-01 | Jefferson Health Plans + $0 Deductible + Gold + HMO + On Exchange |
| 93909PA0010006-02 | Jefferson Health Plans + $0 Deductible + Gold + HMO + No Cost Sharing |
| 93909PA0010006-03 | Jefferson Health Plans + $0 Deductible + Gold + HMO + Limited Cost Sharing |
| 93909PA0010007-00 | Jefferson Health Plans + Total + Gold + HMO + Off Exchange |
| 93909PA0010007-01 | Jefferson Health Plans + Total + Gold + HMO + On Exchange |
| 93909PA0010007-02 | Jefferson Health Plans + Total + Gold + HMO + No Cost Sharing |
| 93909PA0010007-03 | Jefferson Health Plans + Total + Gold + HMO + Limited Cost Sharing |
| 93909PA0010008-00 | Jefferson Health Plans +$0 Deductible Value + Silver + HMO + Off Exchange |
| 93909PA0010009-00 | Jefferson Health Plans + Balanced Value+ Silver + HMO + Off Exchange |
| 93909PA0010010-00 | Jefferson Health Plans + Total Value + Silver + HMO + Off Exchange |
| 19702PA0010001-00 | Jefferson Health Plans + $0 Deductible + Bronze + PPO + Off Exchange |
| 19702PA0010001-01 | Jefferson Health Plans + $0 Deductible + Bronze + PPO + On Exchange |
| 19702PA0010001-02 | Jefferson Health Plans + $0 Deductible + Bronze + PPO + No Cost Sharing |
| 19702PA0010001-03 | Jefferson Health Plans + $0 Deductible + Bronze + PPO + Limited Cost Sharing |
| 19702PA0010002-00 | Jefferson Health Plans + Total + Bronze + PPO + Off Exchange |
| 19702PA0010002-01 | Jefferson Health Plans + Total + Bronze + PPO + On Exchange |
| 19702PA0010002-02 | Jefferson Health Plans + Total + Bronze + PPO + No Cost Sharing |
| 19702PA0010002-03 | Jefferson Health Plans + Total + Bronze + PPO + Limited Cost Sharing |
| 19702PA0010003-00 | Jefferson Health Plans + Value + Bronze + PPO + Off Exchange |
| 19702PA0010003-01 | Jefferson Health Plans + Value + Bronze + PPO + On Exchange |

| QHP ID | Plan Name |
|---|---|
| 19702PA0010003-02 | Jefferson Health Plans + Value + Bronze + PPO + No Cost Sharing |
| 19702PA0010003-03 | Jefferson Health Plans + Value + Bronze + PPO + Limited Cost Sharing |
| 19702PA0010004-00 | Jefferson Health Plans + $0 Deductible + Silver + PPO + Off Exchange |
| 19702PA0010004-01 | Jefferson Health Plans + $0 Deductible + Silver + PPO + On Exchange |
| 19702PA0010004-02 | Jefferson Health Plans + $0 Deductible + Silver + PPO + No Cost Sharing |
| 19702PA0010004-03 | Jefferson Health Plans + $0 Deductible + Silver + PPO + Limited Cost Sharing |
| 19702PA0010004-04 | Jefferson Health Plans + $0 Deductible + Silver + PPO + 73% |
| 19702PA0010004-05 | Jefferson Health Plans + $0 Deductible + Silver + PPO + 87% |
| 19702PA0010004-06 | Jefferson Health Plans + $0 Deductible + Silver + PPO + 94% |
| 19702PA0010005-00 | Jefferson Health Plans + Balanced + Silver + PPO + Off Exchange |
| 19702PA0010005-01 | Jefferson Health Plans + Balanced + Silver + PPO + On Exchange |
| 19702PA0010005-02 | Jefferson Health Plans + Balanced + Silver + PPO + No Cost Sharing |
| 19702PA0010005-03 | Jefferson Health Plans + Balanced + Silver + PPO + Limited Cost Sharing |
| 19702PA0010005-04 | Jefferson Health Plans + Balanced + Silver + PPO + 73% |
| 19702PA0010005-05 | Jefferson Health Plans + Balanced + Silver + PPO + 87% |
| 19702PA0010005-06 | Jefferson Health Plans + Balanced + Silver + PPO + 94% |
| 19702PA0010006-00 | Jefferson Health Plans + Total + Silver + PPO + Off Exchange |
| 19702PA0010006-01 | Jefferson Health Plans + Total + Silver + PPO + On Exchange |
| 19702PA0010006-02 | Jefferson Health Plans + Total + Silver + PPO + No Cost Sharing |
| 19702PA0010006-03 | Jefferson Health Plans + Total + Silver + PPO + Limited Cost Sharing |
| 19702PA0010006-04 | Jefferson Health Plans + Total + Silver + PPO + 73% |
| 19702PA0010006-05 | Jefferson Health Plans + Total + Silver + PPO + 87% |
| 19702PA0010006-06 | Jefferson Health Plans + Total + Silver + PPO + 94% |
| 19702PA0010007-00 | Jefferson Health Plans + $0 Deductible + Gold + PPO + Off Exchange |
| 19702PA0010007-01 | Jefferson Health Plans + $0 Deductible + Gold + PPO + On Exchange |
| 19702PA0010007-02 | Jefferson Health Plans + $0 Deductible + Gold + PPO + No Cost Sharing |
| 19702PA0010007-03 | Jefferson Health Plans + $0 Deductible + Gold + PPO + Limited Cost Sharing |
| 19702PA0010008-00 | Jefferson Health Plans + Total + Gold + PPO + Off Exchange |
| 19702PA0010008-01 | Jefferson Health Plans + Total + Gold + PPO + On Exchange |
| 19702PA0010008-02 | Jefferson Health Plans + Total + Gold + PPO + No Cost Sharing |
| 19702PA0010008-03 | Jefferson Health Plans + Total + Gold + PPO + Limited Cost Sharing |
| 19702PA0010009-00 | Jefferson Health Plans + Value + Gold + PPO + Off Exchange |
| 19702PA0010009-01 | Jefferson Health Plans + Value + Gold + PPO + On Exchange |
| 19702PA0010009-02 | Jefferson Health Plans + Value + Gold + PPO + No Cost Sharing |
| 19702PA0010009-03 | Jefferson Health Plans + Value + Gold + PPO + Limited Cost Sharing |

# Jefferson Health Plans Individual and Family Plans Coverage

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

- Members should reach out to Jefferson Health Plans Member service team, and Providers should utilize our Jefferson Health Plans Provider Services Helpline. See **Contact Information** in **Chapter 1**.

1. Receive written and verbal confirmation of the service coverage.
2. Determine if Prior Authorization is needed or has been completed.
3. Schedule service*.
4. Follow up with Jefferson Health Plans with any issues or questions.

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

| | Includes all Individual and Family Plans HMO | | |
|---|---|---|---|
| | **Tier 1** | **Tier 2** | **Out-of-Network** |
| **Dental Services** | | | |
| **Accidental Dental** | Covered | Covered | Not Covered |
| **Dental Check-Up for Children** | Not Covered | Not Covered | Not Covered |
| **Basic Dental Care – Child** | Not Covered | Not Covered | Not Covered |
| **Major Dental Care – Child** | Not Covered | Not Covered | Not Covered |
| **Orthodontia – Child** | Not Covered | Not Covered | Not Covered |
| **Routine Dental Services – Adult** | Not Covered | Not Covered | Not Covered |
| **Basic Dental Care – Adult** | Not Covered | Not Covered | Not Covered |
| **Major Dental Care – Adult** | Not Covered | Not Covered | Not Covered |
| **Orthodontia – Adult** | Not Covered | Not Covered | Not Covered |
| **Vision Services** | | | |
| **Eyeglasses for Children** | Covered | Covered | Not Covered |
| **Routine Eye Exam – Adult** | Not Covered | Not Covered | Not Covered |
| **Routine Eye Exam for Children (1 Exam per Plan Year)** | Covered | Covered | Covered |
| **Medical Services** | | | |
| **Abortion for Which Public Funding is not Prohibited** | Covered | Covered | Not Covered |
| **Acupuncture** | Not Covered | Not Covered | Not Covered |
| **Allergy Testing** | Covered | Covered | Not Covered |
| **Bariatric Surgery** | Not Covered | Not Covered | Not Covered |

| | Includes all Individual and Family Plans HMO | | |
|---|---|---|---|
| | Tier 1 | Tier 2 | Out-of-Network |
| Chemotherapy | Covered | Covered | Not Covered |
| Chiropractic Care (20 visits per year) | Covered | Covered | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered | Not Covered |
| Delivery and All Inpatient Services for Maternity Care | Covered | Covered | Not Covered |
| Diabetes Education | Covered | Covered | Not Covered |
| Dialysis | Covered | Covered | Not Covered |
| Durable Medical Equipment | Covered | Covered | Not Covered |
| Emergency Room Services | Covered | Covered | Covered |
| Emergency Transportation/Ambulance | Covered | Covered | Covered |
| Gender Affirming Care | Not Covered | Not Covered | Not Covered |
| Habilitation PT/OT Services (30 combined per Year) | Covered | Covered | Not Covered |
| Habilitation Speech Therapy Services (30 per Year) | Covered | Covered | Not Covered |
| Hearing Aids | Not Covered | Not Covered | Not Covered |
| Home Health Care Services (60 Visits per Year) | Covered | Covered | Not Covered |
| Hospice Services | Covered | Covered | Not Covered |
| Imaging (CT/PET Scans, MRIs) | Covered | Covered | Not Covered |
| Infertility Treatment (Artificial Insemination) | Covered | Covered | Not Covered |
| Infusion Therapy | Covered | Covered | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay) | Covered | Covered | Not Covered |
| Inpatient Physician and Surgical Services | Covered | Covered | Not Covered |
| Laboratory Outpatient and Professional Services | Covered | Covered | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered | Not Covered |
| Mental Health/Substance Abuse Outpatient Visits | Covered | Covered | Not Covered |
| Mental/Behavioral Health/SUD Inpatient Services | Covered | Covered | Not Covered |
| Nutritional Counseling (6 visits per Year) | Covered | Covered | Not Covered |
| Other Practitioner Office Visit | Covered | Covered | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Covered | Covered | Not Covered |
| Outpatient Cardiac, Pulmonary, and Respiratory Rehabilitation Services (36 Visits per Year) | Covered | Covered | Not Covered |
| Outpatient Surgery Physician/Surgical Services | Covered | Covered | Not Covered |
| Prenatal and Postnatal Care | Covered | Covered | Not Covered |
| Preventive Care/Screening/Immunization | Covered | Covered | Not Covered |
| Primary Care Visit to Treat an Injury or Illness | Covered | Covered | Not Covered |
| Private Duty Nursing | Not Covered | Not Covered | Not Covered |
| Prosthetic Devices | Covered | Covered | Not Covered |

| | Includes all Individual and Family Plans HMO | | |
|---|---|---|---|
| | Tier 1 | Tier 2 | Out-of-Network |
| Radiation Inpatient and Outpatient Physician Services | Covered | Covered | Not Covered |
| Radiation Office Visit | Covered | Covered | Not Covered |
| Reconstructive Surgery | Covered | Covered | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy (30 visits combined per year) | Covered | Covered | Not Covered |
| Rehabilitative Speech Therapy (30 visits per year) | Covered | Covered | Not Covered |
| Routine Foot Care | Not Covered | Not Covered | Not Covered |
| Skilled Nursing Facility (120 Inpatient days per year) | Covered | Covered | Not Covered |
| Specialist Visit | Covered | Covered | Not Covered |
| Tobacco Cessation (2 attempts per year) | Covered | Covered | Not Covered |
| Transplant | Covered | Covered | Not Covered |
| Treatment for Temporomandibular Joint Disorders | Not Covered | Not Covered | Not Covered |
| Urgent Care Centers or Facilities | Covered | Covered | Not Covered |
| Virtual Care – Primary Care Visit | Covered | Covered | Not Covered |
| Virtual Care – Specialist Visit | Covered | Covered | Not Covered |
| Weight Loss Programs | Not Covered | Not Covered | Not Covered |
| Well Baby Visits and Care | Covered | Covered | Not Covered |
| X-rays and Diagnostic Imaging | Covered | Covered | Not Covered |
| **Pharmacy Services** | | | |
| Preventive Drugs | Covered | Covered | Not Covered |
| Generic Drugs Tier 1 | Covered | Covered | Not Covered |
| Generic Drugs Tier 2 | Covered | Covered | Not Covered |
| Preferred Brand Drugs | Covered | Covered | Not Covered |
| Non-Preferred Brand Drugs | Covered | Covered | Not Covered |
| Specialty Drugs | Covered | Covered | Not Covered |

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

| | Includes all Individual and Family Plans PPO | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Dental Services** | | |
| Accidental Dental | Covered | Not Covered |
| Dental Check-Up for Children | Not Covered | Not Covered |
| Basic Dental Care – Child | Not Covered | Not Covered |
| Major Dental Care – Child | Not Covered | Not Covered |
| Orthodontia – Child | Not Covered | Not Covered |
| Routine Dental Services – Adult | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| Major Dental Care – Adult | Not Covered | Not Covered |
| Orthodontia – Adult | Not Covered | Not Covered |
| **Vision Services** | | |
| Eyeglasses for Children | Covered | Not Covered |
| Routine Eye Exam – Adult | Not Covered | Not Covered |
| Routine Eye Exam for Children (1 Exam per Plan Year) | Covered | Not Covered |
| **Medical Services** | | |
| Abortion for Which Public Funding is not Prohibited | Covered | Not Covered |
| Acupuncture | Not Covered | Not Covered |
| Allergy Testing | Covered | Not Covered |
| Bariatric Surgery | Not Covered | Not Covered |
| Chemotherapy | Covered | |
| Chiropractic Care (20 visits per year) | Covered | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Delivery and All Inpatient Services for Maternity Care | Covered | Not Covered |
| Diabetes Education | Covered | Not Covered |
| Dialysis | Covered | Not Covered |
| Durable Medical Equipment | Covered | Not Covered |
| Emergency Room Services | Covered | Covered |
| Emergency Transportation/Ambulance | Covered | Covered |
| Gender Affirming Care | Not Covered | Not Covered |
| Habilitation PT/OT Services (30 combined per Year) | Covered | Not Covered |
| Habilitation Speech Therapy Services (30 per Year) | Covered | Not Covered |
| Hearing Aids | Not Covered | Not Covered |
| Home Health Care Services (60 Visits per Year) | Covered | Not Covered |
| Hospice Services | Covered | Not Covered |
| Imaging (CT/PET Scans, MRIs) | Covered | Not Covered |

| | Includes all Individual and Family Plans PPO | |
|---|---|---|
| | In-Network | Out-of-Network |
| Infertility Treatment (Artificial Insemination) | Covered | Not Covered |
| Infusion Therapy | Covered | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay) | Covered | Not Covered |
| Inpatient Physician and Surgical Services | Covered | Not Covered |
| Laboratory Outpatient and Professional Services | Covered | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Mental Health/Substance Abuse Outpatient Visits | Covered | Not Covered |
| Mental/Behavioral Health/SUD Inpatient Services | Covered | Not Covered |
| Nutritional Counseling (6 visits per Year) | Covered | Not Covered |
| Other Practitioner Office Visit | Covered | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Covered | Not Covered |
| Outpatient Cardiac, Pulmonary, and Respiratory Rehabilitation Services (36 Visits per Year) | Covered | Not Covered |
| Outpatient Surgery Physician/Surgical Services | Covered | Not Covered |
| Prenatal and Postnatal Care | Covered | Not Covered |
| Preventive Care/Screening/Immunization | Covered | Not Covered |
| Primary Care Visit to Treat an Injury or Illness | Covered | Not Covered |
| Private Duty Nursing | Not Covered | Not Covered |
| Prosthetic Devices | Covered | Not Covered |
| Radiation Inpatient and Outpatient Physician Services | Covered | Not Covered |
| Radiation Office Visit | Covered | Not Covered |
| Reconstructive Surgery | Covered | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy (30 visits combined per year) | Covered | Not Covered |
| Rehabilitative Speech Therapy (30 visits per year) | Covered | Not Covered |
| Routine Foot Care | Not Covered | Not Covered |
| Skilled Nursing Facility (120 Inpatient days per year) | Covered | Not Covered |
| Specialist Visit | Covered | Not Covered |
| Tobacco Cessation (2 attempts per year) | Covered | Not Covered |
| Transplant | Covered | Not Covered |
| Treatment for Temporomandibular Joint Disorders | Not Covered | Not Covered |
| Urgent Care Centers or Facilities | Covered | Not Covered |
| Virtual Care – Primary Care Visit | Covered | Not Covered |
| Virtual Care – Specialist Visit | Covered | Not Covered |

| | Includes all Individual and Family Plans PPO | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Weight Loss Programs** | Not Covered | Not Covered |
| **Well Baby Visits and Care** | Covered | Not Covered |
| **X-rays and Diagnostic Imaging** | Covered | Not Covered |
| **Pharmacy Services** | | |
| **Preventive Drugs** | Covered | Not Covered |
| **Generic Drugs Tier 1** | Covered | Not Covered |
| **Generic Drugs Tier 2** | Covered | Not Covered |
| **Preferred Brand Drugs** | Covered | Not Covered |
| **Non-Preferred Brand Drugs** | Covered | Not Covered |
| **Specialty Drugs** | Covered | Not Covered |

## Prior Authorization for Inpatient Services

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. **FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED**.

Prior Authorization can be obtained by the member, the member's Family Member(s) or the Provider by calling the number on the back of the ID card.

To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, members can visit JeffersonHealthPlans.com, or call us at the number on the back of their ID card. Providers can visit our Prior Authorizations webpage.

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both whether admission to the hospital and whether continued confinement in the hospital are Medically Necessary and eligible for coverage under the terms and conditions of this Policy.

## Prior Authorization for Outpatient Services

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits. **FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.**

Prior Authorization can be obtained by the member, the member's Family Member(s) or the Provider by calling the number on the back of the ID card.

To verify Prior Authorization requirements for outpatient services, members can call us at the number on the back of their ID card, or visit JeffersonHealthPlans.com. Providers can visit our Prior Authorizations webpage.

## Prior Authorization Is Not a Guarantee of Payment

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

Even if a service or product receives prior authorization, it is essential that the provider of that service or product has all required documentation in their records which must be available upon request. Providers must be familiar with required documentation for the services/products which they supply.

## Retrospective Review

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

## Prior Authorization of Prescription Drugs

Prior Authorization is required for certain Prescription Drugs and Related Supplies. For complete, detailed information about Prescription Drug authorization procedures, exceptions and Step Therapy, please refer to the section of this Policy titled "Prescription Drug Benefits."

To verify Prior Authorization requirements for Prescription Drugs and Related Supplies, including which Prescription Drugs and Related Supplies require authorization, visit our **Prior Authorizations** webpage.

Prior authorization requests for Home Infusion services must be submitted by the Home Infusion vendor directly to Jefferson Health Plans Ancillary Prior Authorization Department. Requests can be submitted via the provider portal or if the portal is down by fax to 215-967-4491.

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

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

For additional prior authorization guidelines, visit our **Prior Authorizations** webpage.

## Benefit Schedule

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

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

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

### Participating Hospitals, Participating Physicians and Other Participating Providers

Covered Expenses for services provided by Participating Providers are based on our negotiated rate. Participating providers have agreed NOT to balance bill members for covered services beyond the member cost share amounts set forth in the Policy.

Participating providers may charge the insured person for services that are not covered services under the Policy. In addition, participating providers will file claims with us for the insured person and will request prior authorization when it is required.

Be sure to check with the provider prior to an appointment to verify that the provider is currently contracted with us.

### Emergency Services

Covered expenses incurred for the treatment of an emergency medical condition provided in the emergency department of a non-participating hospital or of a licensed outpatient emergency department are paid as described in the benefit schedule. Any additional expenses incurred for services of a non-participating provider after the patient is stabilized and his/her condition permits transfer to a participating hospital and/or to the care of a participating physician are not covered, except as stated in the Other Circumstances section below. for such covered services, the health benefit plan will reimburse the non-participating hospital-based provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the non-participating hospital-based provider, and the non-participating hospital-based provider cannot ask the member to give up their protections not to be balanced billed. If the member receives other services at a participating hospital or other participating facility provider, non-participating providers cannot balance bill the member, unless the member gives written consent and gives up the protections not to be balanced billed.

### Hospital-Based Provider

When covered services are received from a hospital-based provider (including anesthesiologists, radiologists, pathologists and other ancillary providers) while inpatient at a participating hospital or receiving outpatient covered services at a participating facility (i.e., hospital outpatient department or ambulatory surgical center) provider and are being treated by a participating professional provider, benefits will be received for the covered services provided by the non-participating hospital-based provider. For such covered services, the health benefit plan will reimburse the non-participating hospital-based provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the non-participating hospital-based provider, and the non-participating hospital-based provider cannot ask the member to give up their protections not to be balanced billed. If the member receives other services at a participating hospital or other participating facility provider, non-participating providers cannot balance bill the member, unless the member gives written consent and gives up the protections not to be balanced billed.

### Other Circumstances

Covered expenses for non-emergency, medically necessary services of a non-participating provider will be paid according to the participating provider cost share shown in the benefit schedule in the following cases:

- When reasonable and appropriate treatment of the disease, illness or injury present is unavailable from a participating provider, or
- For any other reason we determine, based on the unique fact pattern present that it is reasonable to receive services from a non-participating provider

## Preventive Benefit Schedule

The preventive benefit schedule is a reference tool for planning preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the

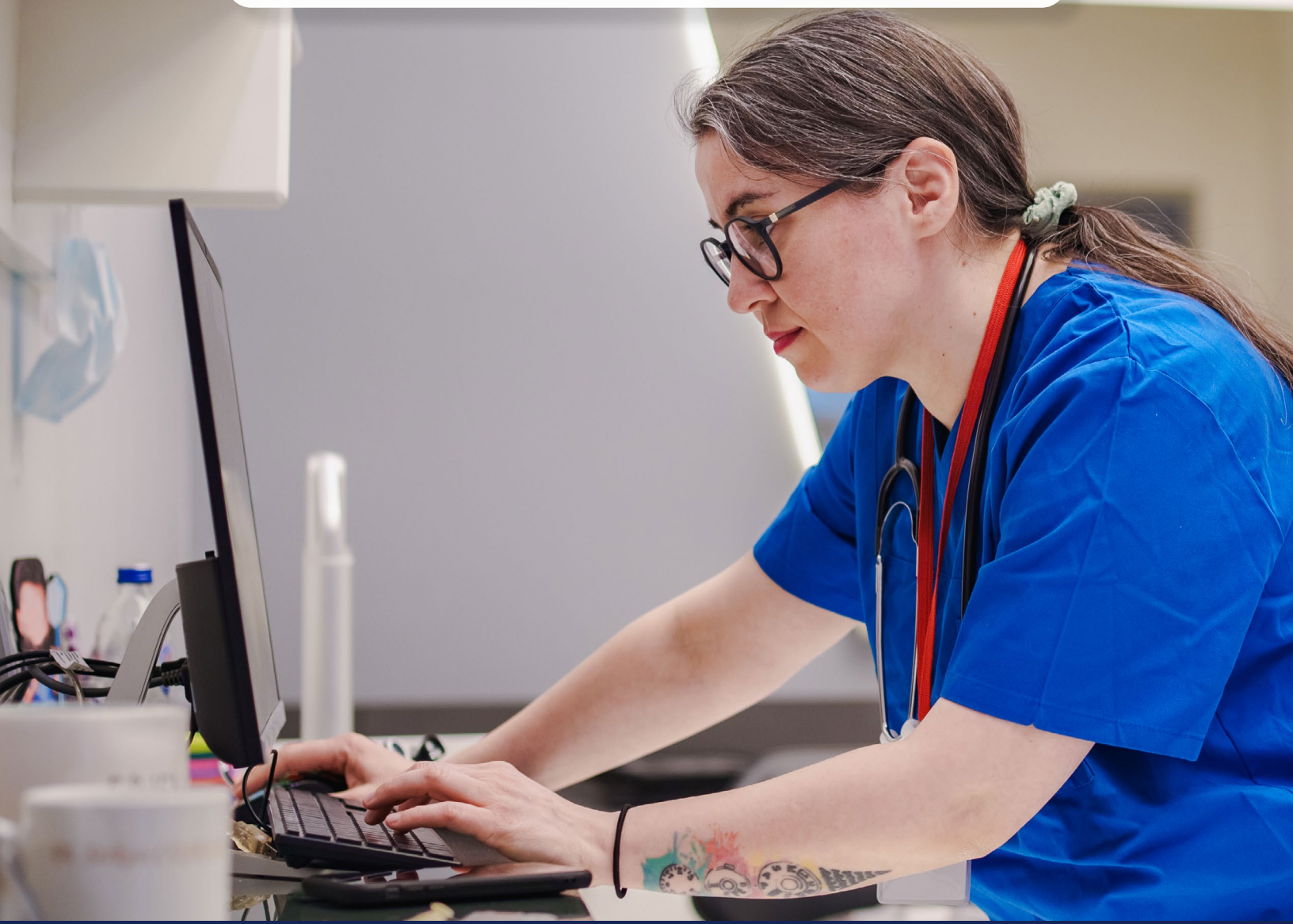
content of this schedule is subject to change. A member's specific needs for preventive services may vary according to personal risk factors. The health care provider is always the best resource for determining if a member is at increased risk for a condition. Some services may require precertification/preapproval. The complete preventive benefit schedule can be found in the appendix. For questions about this schedule, precertification/preapproval, or benefit coverage, please call the Provider Services Helpline.

# Chapter 8: Utilization Management

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

**Topics:** Important topics from this chapter include:

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



# Overview

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

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

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

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

# Providing Appropriate Medical Care for Members

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



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

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

# Medically Necessary Services

## Medically Necessary: Jefferon Health Plans EverWell (Medical Assistance)

A service or benefit is medically necessary if it is compensable under the Medicaid program and if it meets any one of the following standards:

- Request for services must be ordered by a practitioner as directed by regulatory guidelines.
- The service/benefit will or is reasonably expected to prevent the onset of an illness, condition or disability.
- The service/benefit will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service/benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

## Medically Necessary: Jefferson Health Plans Medicare Advantage Program

A service or benefit is medically necessary if it is compensable under Medicare's program and if it meets the following:

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

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

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

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

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

## Medical Necessity or Medically Necessary and Appropriate: Jefferson Health Plans CHIP

Refers to services or supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

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

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

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

### Medical Necessity: Jefferson Health Plans Individual and Family Plans

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, which meet accepted standards of medicine. These services must be:

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Evidence-based
- Not primarily for the convenience of the patient, physician, or other health care provider.

**Authorizations are not a guarantee of payment.**

## Medicare Members' Plan Directed Care

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

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

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

# Timeliness of Utilization Management Decisions

## Non-Drug Turnaround times:

| Service/Procedure | Line of Business | Determination time |
|---|---|---|
| **Utilization Management** | Medicaid/CHIP | **Standard:** 48 hours to 2 business days for OP ancillary<br>**Standard inpatient:** 2 business days<br>**Post-acute:** 14 days<br>**Urgent:** 24 hours |
| **Utilization Management** | Medicare | **Inpatient:** 14 calendar days<br>**Post-acute:** 7 calendar days |
| **Ancillary Services** | Medicare & ACA | **Standard:** 7 calendar Days<br>**Expedited:** 72 hours |
| **Utilization Management (no clinical)** | ACA | 72 hours |
| **Utilization Management (with clinical)** | ACA | 24 hours |
| **Pre-cert** | Medicaid/CHIP | **Standard:** 2 business days<br>**Expedited:** 24 hours |
| **Pre-cert** | Medicare | **Standard:** 7 calendar days<br>**Expedited:** 72 hours |
| **Pre-cert (Standard)** | ACA | 15 calendar days |
| **Pre-cert (Urgent)** | ACA | 2 business days |
| **Retro** | All | 30 calendar days |

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

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

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

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

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

requirements utilizing mandated notification templates, which include associated complaint/grievance/Fair Hearing rights.

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

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

Please note below regarding Urgent/expedited requests:

### Medicare Expedited Authorization Requests:

Per the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, following denial of a request for an expedited initial determination, plans must:

- Transfer the request to the standard initial determination process.
- Give the enrollee prompt verbal notice of the denial to expedite the request; and
- Deliver a written notice within 3 calendar days of the verbal notice of the denial to expedite the request. See below for notification requirements.

### Denial of a Request for an Expedited Organization Determination:

Notice of the denial of a request for an expedited organization determination must:

- Explain that the MA plan will automatically transfer and process the request using the required timeframe for standard requests;
- Inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA plan's decision not to expedite the determination (MA plans may use a Part C model notice, Notice of Right to an Expedited Grievance);
- Provide instructions about the expedited grievance process and its timeframes; and
- Inform the enrollee of the right to resubmit a request for an expedited determination with a physician, prescribing physician, or other prescriber's support, including that if the enrollee gets the support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically.

### Medicaid/CHIP Urgent Authorization Requests:

- **Urgent Care Services —** Services furnished to an individual who requires services to be furnished within twenty-four (24) hours in order to avoid the likely onset of an Emergency Medical Condition.
- **Urgent Medical Condition —** An illness, injury, or severe condition which, under reasonable standards of medical practice, should 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 term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.

### Referencing Act 146 of 2022:

- Prior authorizations expedited for an urgent health care need:
  - Within 72hrs, if the service has not yet been initiated.
  - Within 24hrs, if it is related to an ongoing urgent health care service and the request is made at least 24hrs prior to reduction or termination of the treatment.
- Prior authorization not meeting urgent health care need:
  - Within 15 days.

# Prior Authorization Guidelines

The following information is provided to our members so that they are aware of the prior authorization process and timeframes. If you have any questions about the information below, please call us at 1-888-991-9023. For pharmacy prior authorizations, please call 1-866-841-7659 or visit the **Prior Authorizations** page of our website for more information on the formulary and drug specific prior authorizations forms.

Jefferson Health Plans EverWell and Jefferson Health Plans CHIP members: Post-Acute admission requires prior authorization and are reviewed for medical necessity and referred to the medical directors for final determination. View guidelines for Prior Authorization submission instructions on the **Provider Portal**.

Sometimes there are services or items that the PCP must ask us to approve for the member.

For our members, services requiring prior authorization can be found on the **Prior Authorizations** page of our website.

## Pre-Service Reconsiderations

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

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

AND

- The failure to submit the information prior to the denial was due to no fault of the provider
  - If you would like to submit a request for Reconsideration, you must do so within 7 days from the date on the denial letter.
- For reviews performed by our vendor, EviCore, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
  - PT/OT/ST and Chiropractic: 855-774-1319
  - Chemotherapy – Outpatient and Home Infusion: 800-540-2406
  - Radiation Therapy: 800-540-2406
  - Radiology, Cardiology, Pain Management, Joint & Spine: 888-693-3210
- For reviews performed by our Utilization Management Department, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:
  - Durable Medical Equipment: 215-849-4749
  - Home Care/Home Infusion: 215-967-4491
  - Shift Care/Medical Day Care: 267-515-6667
  - Air Transport: 267-515-6627
  - Post-Acute: 215-991-4125

# EviCore Prior Authorization Program

*These programs are not applicable to CHIP

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

# Cosmetic Services

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

## Short Procedure Unit (SPU)/ Ambulatory Procedures

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

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

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

## How to Obtain Prior Authorization

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

Providers should obtain prior authorization at least seven days in advance for elective (non-emergent) procedures and services. Authorizations will remain active for 90 days after which the provider will need to re-request. Your request will be processed according to state and federal regulations. Failure to comply with this guideline may result in the medically non-urgent services being delayed.

For elective admissions and transfers to non-participating facilities, the PCP, referring specialist or hospital must call our Inpatient Services Department at 1-866-500-4571 or submit the request through our provider portal. These requests for prior authorization must be made before the anticipated admission. Please include the following:

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

For **Jefferson Health Plans EverWell/Jefferson Health Plans CHIP requests for Home Care authorization** please use the provider portal.

For **Jefferson Health Plans EverWell/Jefferson Health Plans CHIP, and Medicare requests for Elective Admissions** please use the provider portal.

For **Jefferson Health Plans EverWell/Jefferson Health Plans CHIP requests for Maternity Admissions** please use the provider portal.

For **Medicare Advantage Home Care authorization requests**, please use the provider portal.

For **Shift Care/Medical Day Care authorization requests**, please use the provider portal.

For **Transport (all air ambulance or CHIP ground transportation) authorization requests**, please use the provider portal.

*Note: Prior authorization is not needed for Medicaid and Medicare non-emergent ground transportation*

For **Jefferson Health Plans EverWell/Jefferson Health Plans CHIP DME authorization requests**, please use the provider portal.

For **Medicare DME authorizations requests**, please use the provider portal.

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

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

Authorization is not a guarantee of payment. Authorization approvals confirm that the service is approved based on medical necessity, and the information provided at the time of the request. Required documentation that is missing or incomplete at the time of a retroactive review for payment for services, even those already reimbursed, may be subject to payment recoveries. Providers must maintain and produce upon request all required documentation that supports the services billed.

## Pharmacy Prior Authorization

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

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

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

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

**Home Infusion services are covered under the medical benefits.**

**Prior authorization requests for Home Infusion services must be submitted by the Home Infusion vendor directly to our Prior Authorization Department. Requests can be submitted via the provider portal by choosing "Drugs and Biologics" under the "Request Type" dropdown.**

**Do not choose "Outpatient". This will delay the determination.**

**If the provider portal is down, requests may be submitted by fax to 215-967-4491.**

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

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

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

# Clinical Review Process

We use the product's specific definition of medical necessity, Medicare's two midnight rule when applicable, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and available InterQual® criteria as guidelines for the review and decision making. Effective November 3, 2025, we implemented the 2025 InterQual criteria in the following modules:

- Acute Adult Criteria
- Acute Pediatric Criteria
- Long Term Acute Care Criteria
- Acute Rehabilitation
- Subacute & SNF
- Home Care Criteria
- Durable Medical Equipment
- Procedures Criteria
- Guidelines for Surgery and Procedures Performed in the Inpatient Setting
- Providers can request a copy of specific InterQual® Level of Care/Acute Level of Care Criteria — or information about the criteria — by calling the Jefferson Health Plans Inpatient Services Unit at 1-866-500-4571 (prompt 2, prompt 3) from Monday through Friday 9 a.m. – 5:30 p.m. EST. To request a copy of our specific outpatient criteria or related information, please contact Ancillary Services at 1-866-500-4571.

# Inpatient Services UM Process

## Obtaining Inpatient UM Assistance After Business Hours

All admissions as inpatient should be submitted through our provider portal, faxed to 215-967-9247, or called into our Inpatient Services department during normal business hours at 1-866-500-4571, Monday through Friday, 8:30 a.m. to 5 p.m. EST.

All after-hours admissions should be directed to participating facilities. If providers require assistance for urgent issues after business hours, please call 1-866-500-4571 and leave a message, which will be forwarded to an on-call nurse case manager. If non-emergency services (including transfers) cannot be obtained from a participating provider, prior authorization is required.

## Community HealthChoices (CHC) UM Process (Medicaid)

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

## Transfer Admission Requirements

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

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

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

## Elective Admissions

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

Our Inpatient Services department issues a written and verbal notification (including a reference number) to the hospital when determinations are made or completed. Excluding transplantation authorizations, which will remain open for one year. All elective procedure authorizations will remain open for 3 months. If the date of the elective admission changes, we will need to be notified so that the authorization can match the incoming claim.

## Preadmission Services

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

## Elective Admissions at a Non-Participating Provider

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

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

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

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

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

For more information on appeals, please refer to Chapter 13, **Provider Appeals**.

## Emergent Admissions

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

## Emergency Care

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

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

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

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

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

## Concurrent Review Process

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

Medical necessity for acute care hospitals is determined by using the product's specific definition of medical necessity, Medicare's two midnight rule when applicable, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and the InterQual® Level of Care criteria. We do not reimburse at the DRG level if the services do not require acute hospital levels of care.

If the Inpatient Services decision denies or reduces to a lower level of care, a written notice of denial is issued to the hospital. The notice includes instructions for requesting a peer-to-peer reconsideration and pursuing an appeal of this determination. Our Medical Directors are available to discuss medical necessity review decisions with peers by calling 215-967-4570. If the inpatient admission extends longer than 5 days it is expected that a weekly clinical update

with a discharge plan be submitted to our Inpatient Services Department.

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

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

> Jefferson Health Plans
> Inpatient Provider Appeals
> Email: **appeals@jeffersonhealthplans.com**

For more information on appeals, please refer to **Chapter 13**, **Provider Appeals**.

## Notification of Discharge/ Discharge Management

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

We will continue to look to the PCP for all issues related to appropriate utilization. PCPs are responsible for coordinating follow-up care after hospital discharge. While PCP referrals are not required for Medicaid or CHIP, the PCP may direct members to participating specialists when medically necessary. In these plans, the absence of requirement for a physical or electronic PCP referral to a specialist or surgeon does not relieve the PCP of his or her responsibility to remain involved in the care of the member. Failure to provide clinical information by the next assigned review date may result in a denial for untimely clinical review.

## Skilled Nursing Admissions

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

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

- **Jefferson Health Plans EverWell:** Members in a licensed skilled nursing or intermediate care facility are covered by Jefferson Health Plans. Members can be admitted to skilled nursing facilities directly from the community.
- **Jefferson Health Plans CHIP:** Members have a limit of 90 days annually for inpatient medical, skilled nursing and mental health combined.
- **Jefferson Health Plans Individual and Family Plans:** Members have a limit of 120 days per year for skilled nursing facilities.
- **Jefferson Health Plans Medicare Advantage:** Members in a licensed skilled nursing or intermediate care facility are covered by Jefferson Health Plans Medicare Advantage should the services be supported by medical necessity for up to 100 days (no bed hold days reimbursed by Jefferson Health Plans) per episode of illness. Members can be admitted to skilled or intermediate care facilities directly from the community.
  - Jefferson Health Plans Medicare Advantage providers are expected to issue all CMS member notices with appeal rights according to state and federal guidelines/regulations. Each notice includes information on the member's or their representative's right to file an expedited appeal.

- Skilled Nursing Facilities and Home Care Agencies are expected to send a copy of the member's signed Notices of Medicare Non-Coverage (NOMNC) to the appropriate fax number along with keeping the original on file for auditing and compliance purposes.
    - Skilled Nursing facilities should fax completed forms to 215-991-4125.
    - Home Care Agencies should email signed document to homecarenomnc@jeffersonhealthplans.com or fax completed forms to 267-515-6633 upon completion.

## Ancillary Services UM Process

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

Outpatient services that require prior authorization:

- Home Health services. This includes skilled nursing (RN, LPN) visits, home infusion, shift care, home health aide services, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Social Work (SW) visits

Please refer to Chapter 6, **Jefferson Health Plans CHIP Benefits** for prior authorization requirements specific to PT/OT/ST.

- All DME rentals
- All DME purchases with a reimbursement value greater than $500
- Any service(s) performed by non-participating providers, except non-emergent transportation providers
- Any service not listed on the Medical Assistance Fee Schedule, including EPSDT Expanded Services
- Air or water ambulance

## Obtaining Ancillary UM Assistance after Business Hours

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

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

## Ambulance/Non-Emergent Transportation

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

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

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

- **Jefferson Health Plans CHIP:** Members are covered for emergency and behavioral ambulance transportation only.
- **Jefferson Health Plans EverWell:** Non-Emergent Ground Transportation does not require prior authorization from a participating or non-participating provider. Air ambulance

transportation does require authorization but is reviewed post service. We will assist members in accessing non-ambulance transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP). However, we are not financially responsible for payment for these services.

- Our members should be advised to contact the Clinical Care Management Department for support in accessing and setting up transportation options or the BH-MCO in their county of residence for assistance in accessing non-ambulance transportation for behavioral health appointments.
- **Jefferson Health Plans Medicare Advantage:** Members are covered for emergency and non-emergent ambulance transportation. Non-emergent transportation is not reviewed for Medical necessity, and does not require a prior authorization.
  - Jefferson Health Plans Medicare Flex Plus, Prime, Dual Pearl, and Special additionally offer a benefit for routine transportation limited to 25 one-way trips (for Prime and Dual Pearl members), 50 one-way trips (for Flex Plus members), or 65 one-way trips (for Special members) for health services at plan-approved locations yearly. Members can contact the Care Navigation Unit for assistance at 1-866-213-1681.
- **Jefferson Health Plans Individual and Family Plans:** Members are covered for emergency and non-emergent ambulance transportation. Non-emergent ground transportation is not reviewed for Medical necessity, and does not require a prior authorization. Air ambulance transportation does require authorization but is reviewed post service. Deductibles and copays are required, please refer to member's benefit document.

## Durable Medical Equipment (DME) and Medical Supplies

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

All DME purchases and medical supplies with a reimbursement value greater than $500 and all DME rentals must be prior authorized.

PCPs, specialists and hospital discharge planners are directed to contact our Ancillary Services department at 1-866-500-4571.

Because members may lose eligibility or switch plans, DME providers are directed to log on to the **Provider Portal** for verification of the member's continued eligibility and continued enrollment with us, when equipment is authorized for more than a one-month period. Failure to do so could result in claim denials.

Occasionally, members request equipment or supplies that are not traditionally covered. We will reimburse participating DME network providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies that meet for Medical Necessity.

Payment requires that the equipment or service is medically necessary, and the network provider has received prior authorization from us. To receive prior authorization, the requesting network provider should submit through the provider portal or if the portal is down, fax a completed request form and letter of medical necessity or complete prescription to our DME unit at 215-849-4749 for Jefferson Health Plans EverWell/ Jefferson Health Plans CHIP members and 267-515-6636 for Medicare Advantage members.

Forms can be found on the **Forms and Supply** page of our website.

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

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

DME prescription requests **MUST** include:

- Complete signed order by an allowed practitioner (MD, DO, NP, PA, Certified Nurse Midwife, Podiatrist)
- Correct Item/Description with HCPCS codes and monthly billing units for all items requested along with Dates of service being requested
- Name and NPI number of the company supplying the equipment
- Provider contact name telephone and fax number
- Proof of delivery (Delivery Ticket) for COC

Occasionally, additional information is required, and the network provider will be notified for such information. If you have questions regarding any DME item or supply, please contact the DME unit at 1-866-500-4571.

## Home Accessibility DME

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

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

## Medical Supplies

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

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

- Vaporizers (one per calendar year) — covered under pharmacy benefit for under 21
- Humidifiers (one per calendar year) — covered under pharmacy benefit for under 21

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

**Medicare Advantage** insulin and related supplies such as syringes and needles are covered under the pharmacy benefit

## Home Health Services

For all Health Plan members, prior authorization for initial evaluations for homecare services is not required. Once a member has had an initial evaluation, prior authorization will be required for further treatment. If no further treatment is necessary, the initial evaluation request must be submitted through the provider portal or if the provider portal is down, faxed to 215-967-4491 or 267-515-6633 within five business days of the initial visit to get paid for the initial visit.

hysician orders or prescription can be verbally accepted but must be noted and signed as such by a RN. For Medicare Advantage Plans details on orders, please see the **Medicare Benefit Policy Manual**, Chapter 7, **Home Care**. The initial evaluation date must be included in the dates of service on your authorization request.

The following services cannot be billed without an authorization number:

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

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

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

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

Our Ancillary Services Unit will coordinate medically necessary home care needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. All requests for services should be submitted through the provider portal or if the portal is down, faxed to 215-967-4491 to obtain an authorization for Jefferson Health Plans EverWell/Jefferson Health Plans CHIP members. Request forms can be found on the Form and Supply page of our website.

### Medicare Advantage

Jefferson Health Plans home health providers are expected to issue all member CMS notices with appeal rights according to state and federal guidelines/regulations.

Each notice includes information on the member's or their representative's right to file an expedited appeal.

Home health providers are expected to fax the member's signed Notices of Medicare Non-Coverage (NOMNC) to 267-515-6633 or email homecarenomnc@jeffersonhealthplans.com.

## Orthotics and Orthopedic Shoes

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

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

Prior authorization for all members requiring orthopedic shoes and devices with a reimbursement value greater than $500 will continue to be required. Requests for orthotics and/or shoes should be submitted through the provider portal or if the portal is down, faxed to 215-849-4749.

For **Jefferson Health Plans Medicare Advantage** members with diabetes, coverage of the footwear and inserts is based on CMS NCD/LCD Coverage guidelines which are subject to change. For 2026, limited to one of the following within one calendar year:

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

For **Jefferson Health Plans Individual and Family Plans** members, the following Orthoses HCPCS are non-covered: L1902, L1906, L1910, L1930, L1932, L1951, L1971, S1040, L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3170, L3300 – L3485), L3500 – L3595, L3600, L3610, L3620, L3630, L3640.

## EPSDT Expanded Services (Medicaid)

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

## Eligibility for EPSDT Expanded Services

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

## EPSDT Expanded Services Requiring Prior Authorization

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

or if the portal is down, faxed to 215-849-4749 and requests for shift care services (private duty nursing) should be submitted through the provider portal or if the portal is down, faxed to 267-515-6667.

## EPSDT Expanded Services Approval Process

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

## EPSDT Expanded Services Denial Process

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

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

## Medicaid Program Exception Process

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

Program exceptions are allowed for review of requests for:

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

## Medicaid Acute Rehab Inpatient Benefit Limit Exception Process

Jefferson Health Plans EverWell member benefit packages may have limits to inpatient acute rehab.

A request for an exception may be made prospectively before the service has been delivered, or retrospectively after the service is delivered.

The following time frames will be adhered to in addressing benefit exception requests:

- Prospective urgent benefit exception requests: two (2) business days.
- Prospective benefit exception requests: two (2) business days of receipt of complete information. If additional information is required, the provider has 14 calendar days to submit information.
- Decision will be rendered within two (2) business days of the receipt of additional information with written notification generated within two (2) business days of communicating the decision. Written notification is to be received by the member within 21 days.
- Retrospective exception requests: 30 days.

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

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

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

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

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

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

Approved exceptions will be processed according to the prior authorization policy and procedures.

*Note: The inpatient benefit limit exception process does not apply to Medicare or CHIP members.*

## Decision Process for Covering Emerging Medical Technology

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

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

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

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

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

# Provider Appeals

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

## Medicaid Appeals Procedure

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

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

> Inpatient Provider Appeals Department
> Department Email:
> appeals@jeffersonhealthplans.com

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

The Utilization Management Committee (UMC) is a subcommittee of our Quality Management Committee, which serves as a peer review panel and is composed of representatives from our participating providers. The Utilization Management Committee responds to second level appeals. The UMC will complete its review within 30 calendar days of receipt of a second level appeal request and supporting documents. The UMC will communicate the decision to our Inpatient Provider Appeals department, who will inform the facility in writing of the decision within five (5) business days of the UMC's decision. The decision of the UMC is final; no further right of appeal is provided.

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

## Pre-Service Reconsiderations

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

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

AND

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

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

For reviews performed by our vendor, EviCore, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:

- PT/OT/ST and Chiropractic: 855-774-1319
- Chemotherapy - Outpatient and Home Infusion: 800-540-2406
- Radiation Therapy: 800-540-2406
- Radiology, Cardiology, Pain Management, Joint & Spine: 888-693-3210

For reviews performed by our Utilization Management Department, please send requests for Reconsideration via fax to the below numbers and include with your request the information that was previously not available for review:

- Durable Medical Equipment: 215-849-4749
- Home Care/Home Infusion: 215-967-4491
- Shift Care/Medical Day Care: 267-515-6667
- Air Transport: 267-515-6627

## Member Appeals of Denied Services

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

## Out-of-Plan Care

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

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

### Second Opinion

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

## Continuity of Care for New Members

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

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

### For New Members Under Age 21

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

### For Members 21 and Older

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

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

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

## Pregnant Members and Newborns

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

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

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

For Jefferson Health Plans EverWell members, coverage will be provided for the mother's delivery. Inpatient normal newborn stays do not require prior authorization. NICU admissions and/or detained baby admissions will require a prior authorization for payment.

## Direct Access for Our Members

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

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

## Abortion

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

## Specialist as PCP/School-Based Health Centers

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

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

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

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

## Behavioral Health

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

## Mental Health Services and Substance Abuse Treatment

**Jefferson Health Plans EverWell:** For Jefferson Health Plans members, the Behavioral Health Managed Care Organization (BH-MCO) for the county in which the member lives is responsible for coordinating and providing all mental health and drug and alcohol services.

For the complete listing of BH-MCO's by county, visit dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx.

**Jefferson Health Plans Medicare Advantage, Individual and Family Plans and Jefferson Health Plans CHIP:** Appropriate behavioral health services are coordinated for all members in collaboration with Optum. Our care managers work closely with the behavioral health MCO to ensure that each member receives the right care, in the right place and at the right time. Our care managers will assist with making the connection to an appropriate provider for care and follow through to support the ongoing needs and progress of the member.

All services other than emergency services must receive prior authorization by Optum.

- Optum Behavioral Health: 1-877-614-0484

*Note: members are required to contact Optum within 24 hours of an emergency admission.*

Members may self-refer for behavioral health services. However, PCPs and other physical health care providers often need to recommend that a member access behavioral health services. The health care provider or his/her staff can obtain assistance for members needing behavioral health services by calling the toll-free number noted above.

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

- Adhere to state and federal confidentiality guidelines for mental health and drug and alcohol treatment
- Refer Members to the appropriate BH-MCO, once a mental health or drug and alcohol problem is suspected or diagnosed
- Participate in the appropriate sharing of necessary clinical information (to the extent permitted by law) with the Behavioral Health provider including, if requested, all prescriptions the member is taking
- Be available to the Behavioral Health provider for consultation
- Participate in the coordination of care when appropriate
- Connect with social, vocational, educational and human services resources when a need is identified through an assessment

- Refer to the behavioral health provider when it is necessary to prescribe a behavioral health drug, so that the Member may receive appropriate support and services necessary to effectively treat the problem.

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

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)
- EPSDT behavioral health rehabilitation services for members up to age 21

Health care providers may call the Enhanced Member Supports Unit (EMSU) at 1-866-500-4571 whenever they need help referring a member for behavioral health services.

## Coordination with Behavioral Health

**Jefferson Health Plans EverWell:** All EMSU/ Clinical Care Management staff will collaborate with the appropriate Behavioral Health Managed Care Organization (BH-MCO) to coordinate psychiatric services and/or drug and alcohol treatment for any Jefferson Health Plans member. A case manager will assist members interested in treatment by coordinating conference calls with the appropriate providers to ensure that the connection to the provider is completed.

In addition, the staff will assist members with transportation to either behavioral or physical medical appointments by helping them complete application to the Medical Assistance Transportation Program (MATP) (**matp.pa.gov/**). MATP coordinates rides to and from these appointments for Medical Assistance recipients. For MATP county contacts, visit **matp.pa.gov/CountyContact.aspx**. Contact the Enhanced Member Supports Unit (EMSU) at 1-866-500-4571 if you need assistance.

**Jefferson Health Plans CHIP:** Behavioral health services are covered benefits for Jefferson Health Plans CHIP members. Case Managers are available to help Jefferson Health Plans CHIP members with any special coordination needs.

**Jefferson Health Plans Medicare Advantage:** Appropriate behavioral health services are coordinated for all members in collaboration with Optum. Jefferson Health Plans Care Coordinators work closely with the behavioral health vendor to ensure that each member receives the right care, in the right place and at the right time. Our care coordinators will assist with the connection to the provider and follow through to support the ongoing needs and progress of the member.

**Jefferson Health Plans Individual and Family Plans:** Appropriate behavioral health services are coordinated for all members in collaboration with Optum. Jefferson Health Plans Care Coordinators work closely with the behavioral health vendor to ensure that each member receives the right care, in the right place and at the right time. Our care coordinators will assist with the connection to the provider and follow through to support the ongoing needs and progress of the member.

## Anti-Gag Policy

The provider may freely communicate with each member regarding the treatment options available, including information regarding the nature of treatment, alternative treatment, risks of alternative treatments, or the availability of alternative therapies, consultation or tests – regardless of benefit coverage limitations. The provider is expected to educate patients regarding their health needs; share findings of the member's medical history and physical examinations, discuss potential treatment options, side effects and management of symptoms without regard to plan coverage and recognize that the member has the final say in the course of action to take among clinically acceptable choices. No provision of this manual or the Participating Provider Agreement shall prohibit open clinical dialogue between the provider and members.

Our goal is to ensure that all members receive the most appropriate medical care available. We do not directly or indirectly reward physicians, providers, contracted entities, employees or any other individuals participating in utilization review decisions for denying or limiting coverage or service. We also do not provide financial incentives for utilization management decision makers that result in the under-utilization of care or service.

While we may utilize incentives to foster efficient and appropriate care, we do not employ incentives to encourage barriers to care and service. It is therefore expected that all contracted and delegated physicians and providers, as well as employees who deal with utilization review activities, make utilization determinations regarding benefits covered by us based only upon the appropriate use of care and services for the member.

# Chapter 9: Quality Management

**Purpose:** This chapter provides a description of our Quality Management standards.

**Topics:** Important topics from this chapter include:

- Quality Management principles
- Quality Management initiatives



# Overview



Our Quality Management (QM) program supports the commitment of the organization to provide quality care and service in a cost-effective manner to its members. This is reflected in the National Committee for Quality Assurance (NCQA) awarding an accreditation status to our Medical Assistance plan for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

The QM program is an organization-wide, dynamic, systematic program designed to monitor and oversee all aspects and components of care and service. Monitoring activities include credentialing, utilization management, appeals and grievances, complaints, access and availability of practitioners, assessment of member satisfaction, sentinel event monitoring, medical record reviews, pharmacy service drug utilization reviews, peer review and assessment of our service improvements.

Our health promotion initiatives include preventive health screening reminders, an interactive member portal as well as active clinical care management services. We offer a full range of care management services for our members that includes Baby Partners (our Maternity Program), Pediatric Care Coordination (for members under the age of 21), Adult Care Coordination for our adult members with complex medical, behavioral or social-related needs, and Medicare Advantage and Dual Special Needs programs. For a full description of all the programs as well as contact information please go to Chapter 10.

# Quality Management Principle

The QM program is based on the principles and concepts of continuous quality improvement.

The QM program is reviewed and approved annually by our Quality Management Council and Board of Directors. Implementation of all QM activities is monitored by the Senior Director of Population Health and the Chief Medical Officer. Updates may be made as necessary throughout the year. A summary of the QM program annual description and work plan are available on request by calling the Provider Services Helpline. Please visit Chapter 1 for **Contact Information**.

All participating providers are expected to support and participate in the QM program as identified in the provider contracts. Participation by the provider is required to improve the quality of care and services and the member experience. Participation occurs through involvement in various committees and task forces, review and recommendations for draft guidelines, provision of chart copies as requested, providing access to medical records for various chart review studies or investigation of member complaints or quality of care issues, taking part in the credentialing and re-credentialing process, and collection and evaluation of data. Performance data may be used in the development of future quality improvement programs.

## Goals

The primary goals of the QM program are to develop and refine monitoring systems that allow us to identify opportunities for improvement in

the quality of care being delivered and to craft interventions directed at these opportunities with the ultimate goal of improving the health outcomes of our members.

The specific steps in the process include: analyzing data collected by us for selected quality of care and service indicators to assess plan performance; comparing plan performance to established benchmarks and goals; identifying opportunities for improvement as well as root causes or barriers for areas below goals; designing and implementing interventions that will increase the quality of care and service delivered to members; and re-measuring plan performance to identify the effectiveness of the quality improvement interventions and initiatives.

## Program Compliance with Regulatory and Accrediting Bodies

Our comprehensive QM Program is developed and administered in compliance with the standards established by NCQA, the Pennsylvania Department of Human Services (DHS), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID) and the Centers for Medicare & Medicaid Services (CMS).

Annually, we complete HEDIS data collection and tabulation. HEDIS is administered by NCQA and is a standardized and comprehensive set of measures and reports that show how managed care plans compare regarding the care provided to members. Ninety-three measures are reported over six domains: Effectiveness of Care, Access/ Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilizations, Health Plan Descriptive Information and Measures Reported Using Electronic Clinical Data Systems. Examples of these measures include use, accessibility, and availability of services, how the plan manages preventive care for wellness and cancer screenings, and how the plan manages health problems such as heart disease, diabetes, asthma and smoking. The data is an important part of measuring the quality of care provided for our members. Additionally, HEDIS scores impact our NCQA accreditation status.

Further compliance responsibilities are managed through our staff members who are designated as mandated reporters, as defined by the Pennsylvania Family Support Alliance (**pafsa.org/who-are-mandated-reporters/**) and as such must report suspected child abuse to the appropriate authorities.

Additionally, we must ensure that emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Members under the care of the county Children and Youth Agency consistent with their obligations mandated in 18 Pa.C.S. §5106 and all applicable statutes. This includes reporting to Adult Protective Services any suspected abuse or neglect of members over the age of 18.

## Provider Incentive Program

One of the main pillars of our overall quality program is our pay-for-performance (P4P) programs. Our provider P4P program is comprised of two distinct incentive programs:

The "Quality Care Plus" (QCP) Program was implemented in July 2012 and consolidated several separate incentive plans into a single program for our provider network. This program was designed to recognize and reward our family practice, internal medicine, and pediatric physician offices for their performance related to HEDIS and other quality measures.

The "Maternity Quality Care Plus" (MQCP) Program is a specialty incentive program designed to recognize and reward maternity care providers for their performance on maternity-related quality measures.

We also offer an Obstetrical Needs Assessment Form (ONAF) fee-for-service incentive program. All OB providers in the network are eligible to earn incentives for submission of one complete prenatal and one complete postpartum ONAF form that are submitted electronically via the approved platform.

We collaborate with our larger provider groups to design our provider P4P program. We incorporate feedback received from our provider

partners into the program design. In addition, we also analyze our NCQA HEDIS results, state specific mandates and priorities to identify improvement opportunities. Whenever possible, we communicate program updates to providers 3-6 months prior to implementing QCP or MQCP changes. This communication approach allows time for our network to positively impact their first payment cycle with those changes in place.

Every year, we share with our network a QCP and an MQCP program description manual, which describes the program, the requirements, the measures included, and payout targets. More detailed information can be found on our website.

Network Management staff meet with individual PCP and maternity practices to discuss the program, review report cards and formulate process improvement efforts to boost low performing measures. In addition, member-level detail reports identifying gaps in care are provided to practices to facilitate targeted outreach efforts.

## Community Partnerships

We have built strong partnerships within the communities we serve, working closely with local school systems to provide meaningful health education to youth. Our programming covers a wide range of topics—including Breakfast Basics, Anti-Bullying and Cyberbullying, Smoking and Vaping Hazards and Cessation, Online Safety, Safe and Healthy Summers, Asthma Management, and Self-Esteem and Confidence Building—to support the whole health and well-being of students.

We collaborate with a diverse network of community partners, including:

### Youth, Education, and Family Support

- Schools
- Early Head Start Programs
- Neshaminy Coalition for Youth
- Maternal and Baby Health Organizations

### Community Coalitions and Networks

- Community Action Networks
- Community Resource Networks
- Intercounty Collaborations
- Health Center Advisory Committees

### Health Promotion and Prevention

- Immunization Coalitions
- Lead Poisoning Prevention Organizations

### Social Support and Basic Needs

- Food Pantries
- Homeless Advocacy Organizations
- Poverty Forums

### Community and Cultural Organizations

- Faith-Based Organizations
- Concerned Black Men

In 2019, we opened our Community Wellness Center in West Philadelphia, featuring on-site Member Relations, Customer Experience and Medicare Sales teams to support our members. The center includes both a food pantry and a period pantry, ensuring families have access to essential resources. We offer free, public programming for the entire family, including fitness classes (Zumba, line dancing, yoga), job training workshops, and health education classes such as hypertension management, diabetes self-management, and nutrition.

Our second Wellness Center opened in October 2025 in North Philadelphia at Philadelphia Youth Basketball. This center also offers robust fitness and health programming, along with the same suite of health education classes—including hypertension, diabetes self-management, and nutrition—to help community members build long-term wellness habits. We will open additional Community Wellness Centers in the future in two additional locations in Central Pennsylvania.

### Program Components

The QM program utilizes a variety of studies, quality indicators and routine performance monitors that provide an ongoing mechanism for quality improvement. Various performance measures are utilized to evaluate the QM program.

These performance measures include the following, and others:

- Topic-specific focused reviews based on established standards, parameters or guidelines
- Comprehensive medical record review of all primary care physician (PCP), Ob/Gyn and high-volume specialist sites at least every 24 months
- Preventive health/health status reviews (immunization, childhood, adolescent, adult, well elderly, obstetric)
- Population-based studies
- Regulatory programs such as HEDIS, and PA performance measures
- Internal quality of care measures
- Model of Care Compliance for Dual Special Needs Program (D-SNP)
- Clinical and/or service audits as mandated by DHS and/or PID
- Member complaints and/or grievances
- Annual member satisfaction survey (CAHPS)
- Physician access indicators
- Appointment availability indicators
- Annual provider satisfaction surveys
- Sentinel events monitoring
- Drug utilization review
- Inpatient quality of care referrals and Adverse events - Hospital Acquired Conditions (HAC), Other Provider Preventable Condition (OPPC) and Potential Serious Adverse Effects (PSAE)
- Over and underutilization reports
- Continuity and coordination of care monitoring
- Evaluation and oversight of all delegations and subcontractors' quality management programs, including dental and vision services

A summary of our Quality Management annual program description and work plan is available on request by calling us. Please visit **Chapter 1** for **Contact Information**.

*Note: Our specialists choosing to leave the network or otherwise becoming unavailable to members (for example, by limiting their practice) must notify us in advance of that change, so we can notify members under their ongoing care.*

In keeping with NCQA quality standards, we require that specialists provide 60 days advance notification to us when:

- The entire practice terminates its participation with us
- Any single specialist terminates participation under his/her Health Plan contract
- Any single practitioner within a group practice, or the entire specialty group, leaves or becomes unavailable to members

## Quality Initiatives

The Quality Management Council (QMC) and our Health Plan Board of Directors have identified and prioritized activities on which to focus for the future. These initiatives reflect the goals and previous performance levels of our Health Plan, as well as the managed care rules and regulations of the DHS, PID, DOH and CMS. Please refer to **Chapter 10**, **Clinical Care Management** for a listing of our clinical care management programs. The clinical care management programs assist us to continually improve the health outcomes of our members.

### ADA Site Reviews

Our staff performs site assessments of primary care providers. The purpose of the site visit is

to review for factors under the Americans with Disabilities Act (ADA) accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the provider, if different from the building entrance. Site visits will be conducted by a designee of our Network Management Team.

The initial credentialing review process includes a review of medical records to assess performance regarding overall medical record keeping standards for primary care physicians including: pediatricians, family practice and internal medicine. That review is completed by our QM nurses. Sites are reviewed annually to determine if members have been seen; if so, the QM department will request a redacted medical record to assess the medical record keeping standards of the provider site. It is preferred that they send that record electronically prior to the physical site visit being performed by the Network Management representative. Once the redacted medical record is received the QM nurses will conduct their review.

Site review results are forwarded to each practitioner/practice. All deficiencies identified during the site visit must be documented on the site visit tool and reviewed with the provider office staff. A plan of action to remediate must be documented and a re-review must occur within 30 calendar days. If the location fails the second site visit an additional 30 day remediation period will be allowed, at which time a third site visit must occur to review the defined deficiencies. If the location fails the third site visit, the location must be removed from our network until the provider remedies all identified deficiencies. If the provider requests to add that location again in the future, a full site visit will be required and any noted deficiencies must be corrected before that location can be added to our network.

### Member Satisfaction Survey

We partner with an outside agency to perform the Consumer Assessment of Health Providers and Systems (CAHPS) survey in accordance with HEDIS and NCQA requirements. Members are specifically asked to rate quality of service, quality of care and satisfaction with their providers of care, and the health plan. After results are reviewed by the QM Department, the results are presented to internal committees for review and formulation of initiatives to aid in improvement. Providers may be asked to participate in initiatives aimed at increasing customer service awareness.

### Provider Satisfaction Survey

We conduct an annual satisfaction survey of the provider network to assess satisfaction with the plan. The survey tool also allows for comments and recommendations from the provider network. The responses provide a catalyst for an internal review of our programs and services, helping to identify areas of strength and opportunities for improvement. The results are reviewed by the QM Council, a committee that provides input on the findings and our strategies to improve satisfaction and services.

## Provider Quality of Care Sanctions and Appeals

The following section provides an overview of possible provider sanctions and the appeal process associated with Quality Management initiatives and actions.

### Quality of Care Level

Quality of Care levels are numerical codes used to categorize the severity of an event that may constitute a potential adverse effect. These codes are assigned during the investigation and review process by the QM department (levels 0 and 1) or the Committee (> or = to a level 1). There are four levels currently used in this process. These are:

- Level 0 – No Quality of Care Concern(s) Identified
- Level 1 – Quality of Care Concern(s) Identified, with no risk of patient harm
- Level 2 – Quality of Care Concern(s) Identified, with potential for patient harm but not identified (no direct link/causation was established that the quality of care concern(s) identified caused patient harm). This level is assigned by peer review during the Credentialing Committee meeting.

- Level 3 – Quality of Care Concern(s) Identified, Patient harm occurred. This level is assigned by peer review during the Credentialing Committee meeting

## Quality of Care Sanctions

It is our goal to ensure the provision of quality health care services in an efficient and economical setting. A provider may be subject to quality of care review and sanctions by us when a review of an individual incident or a trend of data reveals that a practitioner or provider is not in conformity with local standards of care or practice, quality management and utilization management criteria; has failed to adhere to policies and procedures established by us; or has failed to demonstrate improvement following a specific corrective action process.

- Quality of care sanctions for our providers will be determined on a case-by-case basis.
- Quality of care sanctions may apply to any service provided where a review indicates there was a deviation from the standard of care regarding diagnosis, treatment or expected outcome.

The appeal process applies to any provider who has received a quality-of-care sanction from us.

## Responsibility and Authority

A Health Plan Medical Director will review all potential quality of care sanctions. Sanctions for quality of care will be reported to the Credentialing Committee and to our Chief Medical Officer (CMO). All sanctions that may lead to termination of a provider's Agreement with us are also discussed with the Chief Operating Officer (COO). Both the CMO and COO report to the President of our Health Plan, prior to any termination action being taken.

Cases where a potential for immediate harm to members is identified will be reviewed with the Health Plan CMO or their designee who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

## Sanction Process

If, following review of the individual circumstance, we determine that the provider's treatment and care of a member is not in conformity with local standards of care and practice, quality management and utilization management criteria, or the provider has failed to adhere to policies and procedures established by us, then the Health Plan CMO or designee may issue sanctions. Sanctions may include but are not limited to:

- Closing the provider's panel to new members
- Removing all or part of the provider's panel
- Terminating the provider's agreement
- Transferring members to a new provider
- Imposing financial penalties
- Corrective Action Plan (CAP)

The sanction process will typically work as follows:

- The provider will receive a letter identifying the issue(s) and will be provided an opportunity to conform to the appropriate procedures and protocols within a specified time frame.
- Repeated instances of nonconforming behavior may subject the provider to a second letter and the provider will not be permitted to accept additional members until all issues are resolved to our satisfaction.
- Failure to conform thereafter will be grounds for immediate termination of the provider's agreement with us.

Notwithstanding the foregoing, if, in the sole discretion of the Health Plan, the provider's behavior is egregious, negligent, criminal, or threatens the ability of us to ensure quality health care to members, the provider agreement may be terminated immediately. In the event of such termination, the provider will not be permitted to accept additional members, and the provider's current member panel will be advised that the provider is no longer a physician authorized to provide medical services to our members. Cases when there is a potential for immediate harm

to members will be reviewed with our CMO or designee who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

## Appeal/Sanction Dispute Procedure

The provider may appeal/dispute the proposed quality of care sanctions by presenting a written explanation, dispute letter, to us, Attn: Jefferson Health Plans Legal Affairs Dept., within 30 business days of the notice of action or sanction. The Dispute Letter shall detail the reason(s) such action or quality of care sanction should not be implemented.

If no Dispute Letter is received by us within 30 business days of the notice of action or sanction, then the proposed sanction will become final, and we will implement the sanction as soon as practical.

If the provider timely submits a Dispute Letter, we will appoint either a single hearing officer (not employed by us) or a multi-person Sanction Review Panel to hear the provider's dispute. A sanction hearing date will be scheduled within 60 days of our receipt of the provider's Dispute Letter.

At least 30 business days in advance of the sanction hearing, we shall notify the provider of the date, time, and location of the hearing, as well as the name(s) of the hearing officer or panel members, and the name(s) of any witnesses expected to testify on behalf of the Plan. The hearing will be coordinated by our Health Plan Legal Affairs department.

In the hearing notification letter, we shall notify the provider of his/her right to be represented at the hearing by an attorney or other representative, the provider's right to call, examine and cross-examine witnesses, his/her right to submit a written statement at the close of the hearing, and his/her right, upon timely notice given to us, to have a record made of the hearing at the provider's expense. The hearing notification letter will also notify the provider that if the hearing panel affirms our proposed sanction, the provider is required to pay the reasonable costs of the hearing incurred by us, including but not limited to any expert witness expenses, costs of transcripts and attorney's fees.

At least 10 business days in advance of the hearing, the provider must notify us in writing of the names of the provider's witnesses and all supporting documentation the provider intends to present at the hearing. Also, should the Provider wish to be represented by an attorney or other representative at the hearing, the Provider must also notify us of the representative's name at least 10 business days in advance of the hearing.

The hearing officer or panel shall make a written report of its decision and the basis thereof, within 30 business days of the sanction hearing date. We shall notify the provider of the hearing officer or panel's final decision within 30 business days after its receipt of the hearing panel's conclusion.

Regardless of whether a sanction hearing is held, those incidents that result in a limitation of a physician's clinical privileges for more than 30 business days, or result in a quality of care termination, are generally considered to be a reportable sanction. The reporting to the National Practitioners Data Bank and DHS when applicable is done by us.

## Pharmacy Drug Utilization Review

Our pharmacy drug utilization program is coordinated with our quality assurance programs to achieve quality care through a disease management approach.

The pharmacy Drug Utilization Review Program (DUR) is designed to identify and correct potentially harmful prescribing patterns, enhance community-prescribing standards and detect patterns of fraud and abuse. The policy and procedures meet federal statute/regulations, 42 Code of Federal Regulations (CFR) 456, as well as NCQA guidelines. Our continuous quality improvement philosophy allows for annual evaluation and assessment of the program, resulting in the implementation of improved programs that are responsive to the needs of our members and providers.

The Prospective DUR system provides us with the ability to minimize the number of potentially dangerous conditions that result from improper drug utilization.

The system achieves this objective by reviewing prescription drug claims for therapeutic appropriateness prior to medication dispensing using criteria that include the patient's medical history and clinical parameters focusing on those members with conditions that place them at the highest level of risk for a potentially harmful outcome.

The system evaluates each incoming drug claim when the pharmacist enters the information for the prescription with respect to the member's drug and medical history. The system identifies potential drug therapy problems. Monitoring is accomplished through an online alert message system that transmits a message in conjunction with claim adjudications that may present potential therapeutic problems. When appropriate, the pharmacist receiving this advice then takes additional steps to evaluate the order, such as calling the prescribing physician.

The following drug therapy problem types are evaluated:

- excessive drug dosage (age-specific)
- insufficient drug dosage (age-specific)
- drug pregnancy contraindications
- excessive quantity dispensed
- early refill (over utilization)
- late refill (underutilization)
- drug age contraindications
- drug to drug interactions
- therapeutic duplications
- drug to diagnosis contraindications
- generic product availability

All criteria are rated using the following severity indicators:

- cause serious harm to relatively few people (high risk and low incidence),
- cause relatively minor harm to a large number of people (low risk and high incidence), and
- significantly increase the cost of health care by increasing hospitalizations or other treatment modalities

In the event a medication requires prior authorization, a system alert message will appear, advising the pharmacist to call for prior authorization.

A claim that is submitted either online (or, if previously approved for paper, via paper claim) by a participating pharmacy and subsequently approved for payment that includes DUR messages is subject to post-payment audit and recoupment if written documentation is not maintained that pertains to the message(s) returned with the claim. If a message is returned saying that the approved claim has a dosage that exceeds standards developed by a national database company, and no notation is retrievable that documents a discussion between the pharmacist and the prescriber verifying the high dose, the claim is subject to reversal upon audit. Likewise, a claim paid but returned with duplicate therapy message is subject to reversal unless there is documentation demonstrating that the prescriber spoke with the dispensing pharmacist and approved the concurrent administration of both drugs involved.

## Retrospective Drug Utilization Review

Retrospective Drug Utilization Review (RDUR) provides a focused member-specific review of a particular drug, therapeutic drug class or issue. The review identifies potential opportunities for improvements in the members' therapies or practitioners prescribing practices within the therapeutic class. The RDUR is designed to ensure ongoing periodic examination of pharmacy claims data, including other medical records as appropriate, through computerized drug claims processing and information retrieval systems.

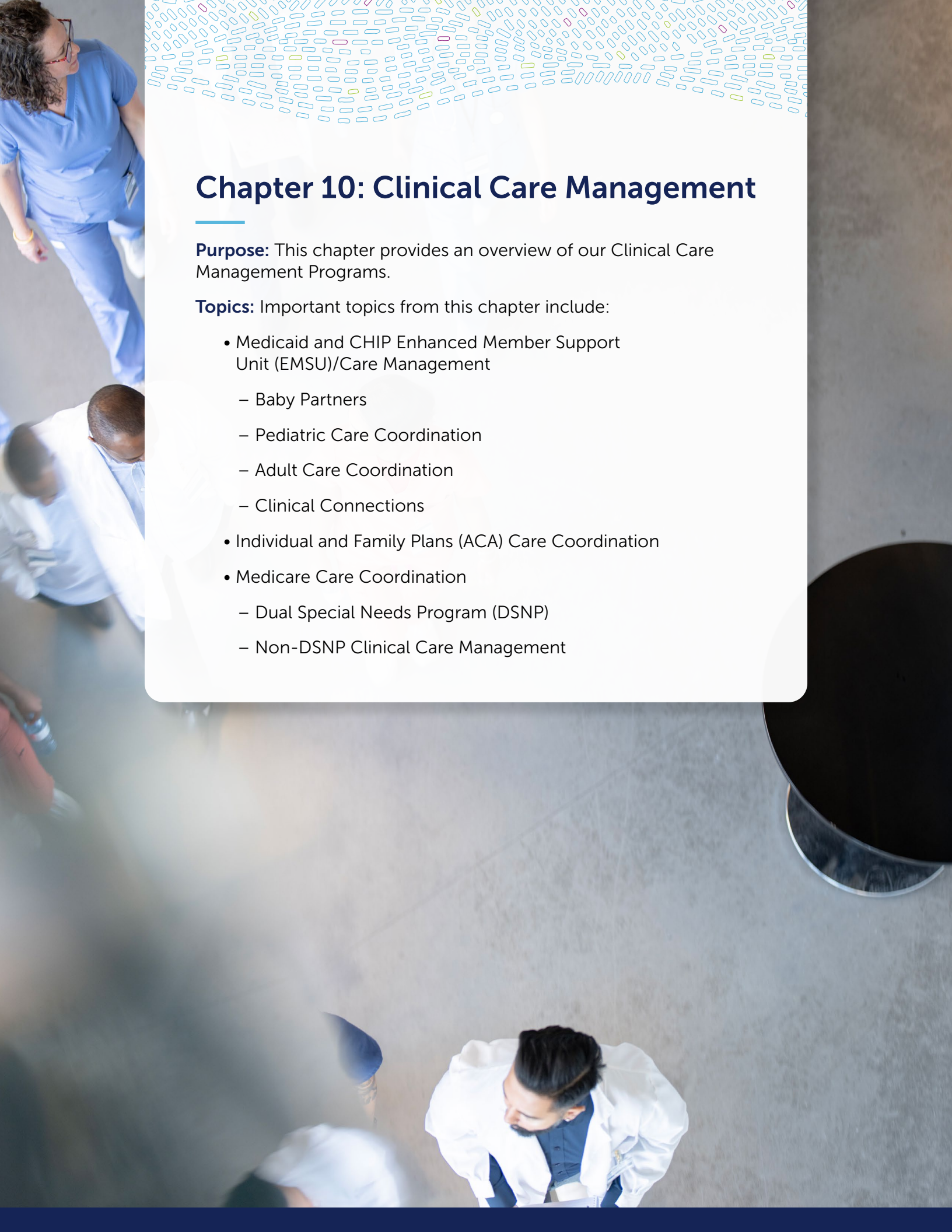
This is used to identify patterns of inappropriate or medically unnecessary care among members enrolled in the plan, or associated with specific drugs or groups of drugs. Retrospective review of providers' and members' drug utilization is performed to improve quality of care and product cost savings that cannot be realized through prospective DUR alone.

Examples that may be addressed by RDUR if concurrent and prospective DUR is not enough:

- FDA withdrawal of medications or safety warnings
- Manufacturer voluntary withdrawal of medications
- Appropriate generic use
- Clinical abuse/misuse
- Drug-disease contraindications
- Drug-drug interactions
- Inappropriate duration of treatment
- Incorrect drug dosage
- Use of formulary medications whenever appropriate
- Over and under utilization
- Therapeutic appropriateness and/or duplication
- Inappropriate use of medications with no diagnosis
- Importance of adherence and compliance to medication
- Inappropriate use of controlled substance

The RDUR program evaluates the appropriateness of therapy from a variety of perspectives, with a primary focus on ensuring safety and efficacy and a secondary focus on reducing unnecessary cost. Clinical pharmacists review flagged profiles based on product selection, dosage, quantity and duration.

Our pharmacists review the clinical appropriateness of proposed interventions and communications with prescribing practitioners may be warranted. Depending upon the finding, our Pharmacy department may provide the prescriber and/or the member education as appropriate. This education may be targeted through specific member intervention letters or through the member newsletters and updates on our website. Our website will also be used to supply education and updates for all members and providers.



# Chapter 10: Clinical Care Management

**Purpose:** This chapter provides an overview of our Clinical Care Management Programs.

**Topics:** Important topics from this chapter include:

- Medicaid and CHIP Enhanced Member Support Unit (EMSU)/Care Management
  - Baby Partners
  - Pediatric Care Coordination
  - Adult Care Coordination
  - Clinical Connections
- Individual and Family Plans (ACA) Care Coordination
- Medicare Care Coordination
  - Dual Special Needs Program (DSNP)
  - Non-DSNP Clinical Care Management

# Clinical Care Management

Clinical Care Management is a department that is responsible for care coordination services (also known as case management services) that promote self-management of health care needs and address the needs of the membership across the life continuum. Clinical Care Management is comprised of special teams that offer a holistic approach to care coordination by addressing social, behavioral, physical health care concerns of the member.

## How are members identified for our case management services?

**Identification:** We proactively identify members who may benefit from care coordination services based on a population stratification model that consists of benefit category, special needs indicator on the eligibility file, ER, inpatient, readmission utilization, severe and persistent mental illness, chronic conditions, care gaps and risk score that is calculated using a software product managed by our Health Care Economics area.

**Referrals:** Members, providers, practitioners, regulatory agencies, Health Plan internal departments such as Pharmacy, Member Relations, Utilization Management; all may refer to any clinical program.

**Interventions:** Include telephonic outreach, mailings, face-to-face case management either in the home setting, virtually or community based.

**Evaluation of the Effectiveness of the Program:** Annually, we evaluate the effectiveness of the programs, based upon reduction in ER use, inpatient admissions, and readmissions.

# Medicaid and CHIP

## Enhanced Member Supports Unit (EMSU)/ Care Management is available to all our members and includes:

**Baby Partners:** A perinatal program that follows expectant mothers from the first notification of pregnancy through at least 84 days post-delivery and may refer mom or baby for continued care coordination if needs are identified.

**Community Based Maternal/Child Home Visiting program:** Our Baby Partners team works with many community organizations that provide home visits to pregnant members and families with children through the first 24 months of life. These programs assist with helping to prepare and navigate parenthood, understand and promote reaching baby's milestones, stressing the importance and reminders on well child visits/ dental care and preventive screenings, sleep guidance and age-appropriate activities. Our Baby Partners team can help you connect families to these programs.

**Adult Care Coordination:** Assists adult members with chronic conditions and/or social needs to obtain all the services that they may need to follow the health care plan of their PCP or Specialist.

**Pediatric Care Coordination:** Assists children with multiple health care concerns to obtain the health care services that they need with strong emphasis on fragile children and children with certain chronic conditions. These care coordinators are well versed in important childhood milestones as well as needed vaccinations and preventive care.

**Clinical Connections:** Provides discharge screenings, health risk assessment follow-up and disease education for members who are not associated with other Health Plan programs.

## What is involved in Care Management/Care Coordination?

Our services are in place to address the needs of the membership across the life continuum – prenatally through adult care needs. A critical component of this includes collaboration on member's identified goals and interventions between the member, families/designated member representative, the member's health care providers and community agencies as appropriate. The assessment tool that is used by staff integrates physical and behavioral health with psycho-social wrap around services to address social determinant needs. All care management programs follow evidence-based guidelines and

standards of care while being mindful of the member's cultural, linguistic, and gender-specific preferences. Care Coordinators assist members in following through the treatment plan outlined by the member's primary care physician (PCP) and/or specialist. The goals of the program are to transition members to self-management and/or help them achieve an optimal state of health. Interventions—which only follow a comprehensive evaluation of the member's health status, (including cognitive functions, psychosocial, vision and hearing needs and clinical history)—may include:

- Proactive assistance in scheduling PCP/ Specialist appointments, dental and behavioral health care appointments as well as maternal home visiting programs as appropriate
- Assistance with PCP selection or other health care providers as requested
- Coordination of care for members in substitute care
- Integration of care plan goals and interventions with the member's specific Behavioral Health MCO's care management team
- Transportation assistance (as needed)
- Support management of chronic conditions through condition education and medication adherence
- Proactive assistance in addressing care gaps specific to the member based on age, gender and chronic condition
- Review of discharge instruction and coordination of care post inpatient stay
- Coordination of home care services and durable medical equipment and other prior authorization needs
- Caregiver coordination (with member's consent)
- Assistance in addressing barriers to health that may include, but are not limited to, food resources and housing concerns
- Linkage to community resources for services such as utility services support and GED and employment opportunities
- Behavioral health referrals and coordination of needed services
- Assistance with medication delivery to ensure compliance
- Explanation of benefits including complaint and grievance filing if applicable
- Assistance with life planning needs
- Smoking cessation resource and program referral (when applicable)
- Dietary counseling/support, as well as food resources, in member's zip code
- Participation in interagency team meetings (as requested).

*Tip: Providers may be eligible to participate in the Maternity Quality Care Plus (MQCP) incentive program. This program rewards maternity care practices based on the quality of care our pregnant members receive. Contact our Network Management staff for more details.*

## Additional Provider Tips:

Providers who have Medicaid members (under the age of 21) assigned to their panels are required to track and outreach to members who are in need of EPSDT services or are not up to date on all EPSDT periodically scheduled needs.

New Medicaid members are required to have a complete physical exam within 45 days of enrollment unless under the care of assigned PCP.

CONNECT assists parents/ families in locating resources and providing information regarding child development ages birth to age 5 by calling 1-800 692-7288 or visiting **connectpa.net/**.

Providers who have CHIP members assigned to their panels are required to track and outreach to members who are in need of services or are not up to date on all required needs.

## Individual and Family Plans Care Coordination

Care Coordination services are available for the members who require assistance with accessing care, coordinating care, identifying community resources for Health-Related Social Needs (HRSN), and educational guidance and support for their illness. Identified barriers, coordination to care, and resources are managed by the Care Coordinator team in partnership with their identified health care providers.

To refer members to any of our clinical care management programs please use the referral form on our website, email clinicalconnections@jeffersonhealthplans.com or call:

- 1-833-705-3751 for pregnant and postpartum member referral or
- 215-845-4797 for all Medicaid, CHIP or Individual and Family Plans member

A Care Management representative will obtain details on the reason for referral and connect you to the appropriate program.

## Medicare Advantage Care Coordination

We make Care Coordination services available to our Medicare members who require assistance with accessing care, coordinating care, identifying community resources for HRSN, and educational guidance and support for their illness. The Care Coordinator evaluates the member's health care needs through a health risk assessment (HRA) for our Dual Special Needs Plans (DSNP) members. The HRA assists us in identifying the medical, functional, cognitive, psychosocial, mental health and any health-related social needs or barriers that may prevent our members from accessing needed care and services. Identified opportunities and barriers, coordination and access needs are managed by the Care Coordinator.

The Care Coordinator works closely with the member/caregiver (s) and provider to achieve agreed upon goals that will improve their health.

Jefferson Health Plans Medicare Advantage Care Coordination is available for all our Medicare Plans in Pennsylvania and New Jersey.

Our Care Coordinators will:

- Complete a Health Risk Assessment Tool (HRAT) to identify a member's needs. HRAT's must be completed for all Medicare DSNP (Special, Dual Pearl and Select Plans) members.
- Assist members to understand and comply with their treatment plan outlined by the member's PCP and/or specialist.
- Assist with arranging transportation to health care appointments.
- Ensure services are in place before, during and after a transition of care.
- Provide preventive health reminders and disease specific education.
- Coordinate behavioral health services.
- Coordinate and collaborate needed Medicaid services provided by Community Health Choices (CHC) plans (DSNP).
- Address HRSN and refer to needed community resources such as housing, food, and transportation.
- Discuss life planning that includes power of attorney, advance directives and living wills.

### Dual Special Needs (D-SNP) Medicare Plan members

As a Jefferson Health Plans Provider your responsibilities related to providing services to our Dual Special Needs Members include:

- Completing Annual Model of Care (MOC) Training. This MOC training describes the goals and objectives of our DSNP MOC program as well as your roles and responsibilities.

- You may access the MOC training via our **Provider Online Courses** webpage.
- You will be contacted via letter by the Jefferson Health Plans Care Coordinator to invite you to attend a formal Interdisciplinary Care Team (ICT) meeting to review and discuss your patient's Individualized Care Plan (ICP).

Attached to the ICT invite letter is your patients ICP. You may contact your patient's Jefferson Health Plans Care Coordinator at any time to change or update the care plan.

# Chapter 11: Provider Practice Standards & Guidelines

**Purpose:** This chapter provides an overview of the current provider practice standards and guidelines used by us.

**Topics:** Important topics from this chapter include:

- Access and appointment standards
- Credentialing/Recredentialing
- Provider office practice standards



# Overview

Providers that participate with us must adhere to certain standards and guidelines to remain a participating provider. This chapter provides documentation of these contractual requirements.

# Access and Appointment Standard

The following table specifies the office access and appointment standards we require provider practices to meet.

| Provider Access and Appointment Standards | | | |
|---|---|---|---|
| **Criteria** | **PCP** | **OBGYN** | **Specialist** |
| **Routine Office Visits** | Within 10 business days | OB: Initial prenatal visit within 24 hours of identification of high risk by Jefferson Health Plans or maternity care provider or immediately if emergency exists.<br><br>First prenatal visit (pregnant 1–3 months): Within 10 days<br><br>First prenatal visit (pregnant 4–6 months): Within 5 days<br><br>First prenatal visit (pregnant 7–9 months): Within 4 days<br><br>GYN: Within 10 days<br><br>OB/GYN: Within 5 days of effective date of enrollment | Otolaryngology, dermatology, pediatric endocrinology, pediatric general surgery, pediatric infectious disease, pediatric neurology, pediatric pulmonology, pediatric rheumatology, dentist, orthopedic surgery, pediatric allergy and immunology, pediatric gastroenterology, pediatric hematology, pediatric nephrology, pediatric oncology, pediatric rehab medicine, pediatric urology, and pediatric dentistry: Within 15 business days<br><br>All other specialists: Within 10 business days |
| **Routine Physical** | Within 3 weeks | N/A | N/A |
| **Preventive Care** | Within 3 weeks | N/A | N/A |
| **Urgent Care** | Within 24 hours | Within 24 hours | Within 24 hours |

| Provider Access and Appointment Standards | | | |
|---|---|---|---|
| **Criteria** | **PCP** | **OBGYN** | **Specialist** |
| **Emergency Care** | Immediately and/or refer to ER | Immediately and/or refer to ER | Immediately and/or refer to ER |
| **First Newborn Visit** | Within 2 weeks | N/A | N/A |
| **Patient with HIV Infection** | Within 7 days of enrollment for any member known to be HIV positive unless the member is already in active care with a PCP or specialist regarding HIV status | N/A | Within 7 days of enrollment for any member known to be HIV positive unless the member is already in active care with a PCP or specialist regarding HIV status |
| **EPSDT** | Within 45 days of enrollment unless the member is already under the care of a PCP and the member is current with screenings and immunizations | N/A | N/A |
| **SSI Recipient** | Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist | Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist | Within 45 days of enrollment unless the enrollee is already in active care with a PCP or specialist |
| **Office Wait Time** | 30 minutes (or up to 1 hour if urgent situation arises) | 30 minutes (or up to 1 hour if urgent situation arises) | 30 minutes (or up to 1 hour if urgent situation arises) |
| **Weekly Office Hours** | At least 20 hours per site | At least 20 hours per site | At least 20 hours per site |
| **Maximum Appointments per Hour** | 6 | N/A | N/A |

### Additional Appointment and Availability Standards

- The PCP or specialist should ensure that the average office waiting time does not exceed 30 minutes. When the physician encounters an unanticipated urgent visit or is treating a patient with a difficult medical need, the wait time should not exceed one hour.
- An appointment system for scheduling all routine visits is also a requirement. At a minimum, this includes an appointment book and written notice given to patients stating date and time of next appointment. Evidence of compliance with these minimum access standards is sought at the time of initial credentialing, at recredentialing, and at interim periods if non-compliant activity is noted.
- For any missed appointment, the PCP or specialist should make three attempts to contact the member about the missed appointment. At least one of such attempts must be a follow-up phone call. Documentation of the notices and telephone calls should be placed in the medical record.
- The hours of operation of a provider must be convenient for and not discriminate against our members. Provider services need to be available 24 hours a day, 7 days a week, when medically necessary.

### Telephone Availability Standards

Telephone availability standards are closely monitored through our member satisfaction surveys, site reviews, and member complaints. These standards are as follows:

- All PCPs must be available to members for consultation regarding an emergency medical condition 24 hours a day, seven days a week.
- After regular office hours, the PCP should return member calls within one hour of when the member called. Coverage may be shared with another PCP participating with us.
- If a PCP uses an answering service, the assigned service person must be capable of taking a message and contacting the physician directly and immediately.

We use the Council for Affordable Quality Health Care (CAQH) online provider application tool. It is required for you to maintain current and accurate information on CAQH and re-attest to the information in your CAQH application as required.

## Medical Information Confidentiality

Issues of confidentiality concerning medical information are addressed in our Notice of Privacy Practices, among other areas. This notice is distributed to all of our members as required by the federal government. It describes how medical information about members may be used, and how members can access this information. This policy is also posted on our **Privacy Practices** webpage under "HIPAA Notice of Privacy Practices."

The HIPAA Notice of Privacy Practices includes:

- How we protect member health information
- Our privacy practice
- How we use or share information

### Member Confidentiality

All Health Plan contracts with health care providers contain a provision titled "Confidentiality and Accuracy of Records." This provision states that the provider agrees to abide by all federal and state laws regarding confidentiality and disclosure and shall treat all enrollees' health and enrollment information, including any medical records or mental health records as confidential in accordance with the provisions of the Agreement, and comply with all applicable laws regarding the confidentiality and disclosure of such health and enrollment information.

When disclosing member information, legal restrictions include those mandated by:

- The Pennsylvania Act 1998-68, the Quality Health Care Accountability and Protection Act, Section 2131 and the Department of Human Services regulations (5100.31 through 5100.39)
- Pennsylvania Act 148, the Confidentiality of HIV-Related Information Act
- The Code of Federal Regulations Title 42, Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records
- Health Insurance Portability and Accountability Act (HIPAA)

It is our policy that:

Any information that identifies a particular member must be safeguarded. Information from, or copies of, records may be released only to authorized individuals, and providers must ensure that unauthorized individuals cannot gain access to or alter member records. Original records must be released only in accordance with federal or state laws, court orders, or subpoenas. Providers must have policies and procedures on safeguarding, releasing and office procedures on patients' confidential medical records.

Records and information must be maintained in an accurate, confidential, and timely manner.

Members must be given timely access to their records and information. (If requested, the provider must supply the member with a copy of his or her paper medical record, at no charge, unless the provider believes that supplying such record is not medically advisable.)

All federal and state laws regarding privacy, confidentiality and disclosure for mental health records, medical records, other health information and member information must be adhered to.

### Provider Confidentiality

Our Credentialing department policies specify that all provider information is maintained in strict confidence and that all provider files are maintained in a secure storage area and are shredded before disposal.

All health care information presented to the peer review committees (Utilization Management, Pharmacy and Therapeutics, and Quality Management) is blinded prior to presentation to the committee members to protect the identity of the individual health care provider.

Health care provider information will be disseminated as required by law in response to a court order or subpoena. This process is handled in conjunction with our Health Plan's Legal Affairs department and follows the rules established by state law. When disclosing provider information, legal restrictions include those mandated by: Title IV of Public Law 910-660, the Health Care Quality Improvement Act of 1986 The Peer Review Protection Act.

### Confidentiality of Other Information

Our participating providers may not disclose (by oral, written, electronic or other means) any financial or other proprietary information except as required by the Department of Human Services, the Pennsylvania Insurance Department or by law.

## Credentialing/Recredentialing

As part of our Quality Management program — as well as National Committee for Quality Assurance (NCQA), Department of Human Services (DHS), Department of Health (DOH), Pennsylvania Insurance Department (PID) and Centers for Medicare & Medicaid Services (CMS) guidelines—participating PCP, specialist, allied health, ancillary and hospital providers undergo an initial credentialing process. Practitioners are recredentialed every three years and they must show evidence of satisfactorily meeting our quality of care and service measures for their members.

Providers who wish to be credentialed by us must submit a complete application and a signed Provider Data Collection form to release information.

We require the use of the CAQH application but will also accept the Pennsylvania standard paper application. Other documents required to complete the credentialing process are as follows: Primary Source Verification (PSV) is completed in alignment with NCQA, DHS, CMS and our credentialing standards. Please visit our **Credentialing/Recredentialing** webpage for our credentialing standards.

The Health Plan does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language and the reporting race and ethnicity is optional and not a requirement.

The process for providers due for recredentialing is initiated three months prior to their recredentialing due date. We will use the CAQH application to verify and update information for recredentialing purposes. If a CAQH application is not on file, we will reach out to the provider to obtain an updated application.

Information that will be required and verified at the time of recredentialing is as follows:

- Signed and dated "Provider Data Collection" form, as applicable
- Signed and dated Provider Questionnaire and Attestation Statement.
- Current state medical license
- Current DEA certificate
- Recertification of board certificate, as applicable
- Official documentation of ongoing CME activity
- Current copy of professional liability insurance face sheet
- Malpractice history, if applicable
- Accreditation certificate (ancillaries and hospitals)
- Hospital privileges (need signed hospital attestation for a participating Health Plan hospital). All specialists need to have admitting privileges. PCPs can have covering arrangement with participating providers.
- Medical Assistance identification number (to obtain an active Medical Assistance identification number, visit the provider enrollment section of the DHS website at **dhs.pa.gov**.
- Sanctions screenings (MediCheck, OIG, SAM, and Security Administration Death Master File) Medicare (CMS) identification number
- NPI number (individual and billing), using NPPES

All PCP sites are required to meet handicap accessibility as mandated by the Americans with Disabilities Act (ADA). Verification of those requirements may be made by a site visit to the practice location or by another means defined by us. PCP sites may attest to their ADA compliance by completing our **ADA attestation**. In addition, medical record audits will be completed upon initial participation into the network and at least every two years to assess compliance with medical record keeping practices. See appendix for ADA and medical record documentation standards.

Compliance with appointment availability standards will also be assessed. Quality review audits are completed every two years and are managed outside of the credentialing and recredentialing cycles. Concerns noted during these reviews are documented and addressed with the provider and could result in a corrective action plan (CAP).

The decision of the Credentialing Committee to accept or deny a practitioner into the network will be communicated in writing by our medical director within 60 days of the credentialing decision. If a provider is denied, the reason for denial and information regarding the appeal process are noted in the denial letter.

We offer each practitioner the right to review any of the information submitted in support of

their credentialing/recredentialing application. Additionally, the practitioner has the right to correct any erroneous information by supplying the corrected information in writing to the Credentialing department. The provider has the right to receive the status of their credentialing or recredentialing application, upon request. The provider also has the right to appeal the decision of the Credentialing Committee.

In compliance with DHS, PID and CMS regulations, we will not employ or contract with any provider/individual (or with any entity that employs or contracts with such provider/individual) who is excluded from participating in Medicaid or Medicare for the provision of any of the following: health care, utilization review, medical social work and/or administrative services.

### Process for Providing Credentialing and Recredentialing Status

The plan will provide acknowledgement of application within 10 days of receipt. Subsequently, an update on the status of the application will be provided every 30 days.

Providers may also check the status of their credentialing or recredentialing application by emailing the Credentialing Department at credentialing@jeffersonhealthplans.com. The Credentialing inbox is monitored daily and a response will be provided within 48 hours of receipt of the initial request.

## PCP Panel Status

All Primary Care Providers (PCPs) who contract with Jefferson Health Plans are given one of the below member panel statuses in our Provider Directory which allows members and our health plan to identify if new patients are being accepted.

- **Open:** PCP is accepting new members to his/her panel.
- **Existing Patients Only:** PCP is only accepting existing members to his/her panel.

In certain and rare circumstances, Jefferson Health Plans may freeze /close a panel (e.g., sanctions, terminations, etc..). If a PCP's panel is frozen/closed, no additional members will be assigned to the PCP panel, and the PCP will not appear in the provider directory.

### Updating Your PCP Panel Status

Upon completion of the initial credentialing process, PCPs are given a status of Open.

If a change in PCP Panel Status is requested at any time after credentialing, providers must provide sixty (60) days advance notice of its intent to close the practice to new patients. Providers must submit the following in writing to datavalidation@jeffersonhealthplans.com.

- Name of provider(s) closing the panel with individual NPI(s).
- Reason for the change request.

To be considered, requests must include all required documentation. Once a request for a panel status change is received, it is reviewed by the Provider Network Management department to determine if the request will be granted. Determinations will be made within 10 business days, and providers will receive written confirmation once the request has been processed.

Any changes to PCP Panel Status will be applied consistently across all Jefferson Health Plans lines of business and products.

For information on how to transfer a member from your panel, please refer to the **Involuntary Transfer section** in Chapter 3, **Member Eligibility and Enrollment**.

## Practice Changes

The Network Management department must be immediately notified in writing when any of the following occurs. All professional provider data changes, can be emailed to

datavalidation@jeffersonhealthplans.com

- Additions/deletions of providers
- Change in payee information (W-9 required)
- Change in hours of operation
- Provider practice name change
- Telephone number change
- Site relocation – Credentialing application and roster is required
- Site location terminations
- Full practice terms
- Change in patient age restrictions
- NPI and PA MAID number changes
- Panel Status Changes

contracting@jeffersonhealthplans.com

- Initial contract
- Change in group/practice ownership
- Tax id change (W-9 form is required)
- NPI Change (W-9 form is required)

providerdata@jeffersonhealthplans.com

- Additions/links/terms of hospital based/ facility based/PT/OT/Speech providers (hospital-based profile or roster required)
- Change in payee information- W9 is required
- Change in hours of operation
- Telephone number change
- Change in age restriction

Initial credentialing files, recredentialing files and request for status can be sent to credentialing@jeffersonhealthplans.com.

* Providers should also check the DHS PROMISe system on a routine basis to confirm demographic data, including all service locations/revalidation dates to ensure information is current and have an active Medical Assistance ID.

Please visit the DHS webpage at PROMISe Enrollment (pa.gov) for requirements and step by step instructions.

### Administrative Terminations

Providers who fail to maintain compliance with our credentialing standards will be presented at the next regularly scheduled Credentialing Committee meeting for discussion and decision making. These are the exceptions to this policy:

| Administrative Terminations | |
|---|---|
| **Circumstance** | **Action upon Health Plan notification** |
| **Loss of medical license** | Provider will be terminated immediately from all lines of business. |
| **Inactive PA MAID with the Commonwealth of Pennsylvania** | Provider will be terminated immediately from our Medicaid network. |
| **Inactive participation with CMS** | Provider will be terminated immediately from our Medicare network. |
| **Suspension or termination from participation in the Medicaid or Medicare programs** | Provider will be terminated immediately from all lines of business. |

We run monthly checks against licensure, DEA, malpractice, and board certification and will send letters to providers in advance of the expiration date of those credentials. If the credential is not renewed and able to be primary source verified prior to the expiration date, the provider will be terminated effective the day following the expiration date of the credential.

*Note: In addition, we also utilize the System for Award Management (SAM) to access the General Service Administration (GSA) precluded list, the OIG system and the MediCheck system. These lists are reviewed during credentialing and recredentialing and twice a month for sanction activity. Any provider who is identified as being precluded will be immediately terminated by us according to the terms of their agreement with us.*

## Voluntary Provider Terminations

Providers are required to provide us with 60 days notice from terminating from the network unless their participating provider agreement stipulates otherwise. This notice must be provided in writing and should be addressed to the notification contact stipulated in the participating provider agreement.

We are required to notify all impacted members of a pending provider termination at least 45 days prior to the effective date of termination. We encourage the provider to issue their own notification to their members when terminating from our network.

## Quality-of-Care Investigations

Quality-of-care (QOC) investigations are conducted by registered nurses. If a potential QOC issue is found, the investigation is reviewed by a medical director. A letter of inquiry is faxed/emailed to the provider to allow for a response to the QOC issue. If need be, the case is presented to the Credentialing Committee for peer review. The provider may be assigned a Corrective Action Plan (CAP) depending on the QOC issue identified. The provider can submit documentation once the CAP is completed.

## Role of the Primary Care Physician (PCP)

Some of our products require members to select a primary care physician (PCP) or gives members the option to select a PCP. The PCP is usually the starting point for a member to receive medical care and acts as the gatekeeper for all future care provided. It is important for the PCP to stay connected with all their members and encourage them to utilize the primary care services available to them.

While we expect that much of our members' needs can and will be addressed by their PCP, we also acknowledge the need for more specialized services and that the member's PCP will use his or her education, experience and best medical judgment to direct members out for additional care when needed. PCP referrals to a specialist are not required for any plan members.

We stress the need for members to stay connected to their PCP (e.g., in cases where they are receiving care from other medical professionals, including but not limited to prescription care), continue to maintain the relationship with their PCP, and ensure that their PCP has access to their most current medical conditions and services received.

Access to PCP care is vitally important to maintaining the health of our members and, when possible, steering them away from the use of emergency rooms when their condition can more appropriately be managed in a PCP office environment. A PCP is required to provide access to care as outlined in the Access and Appointment Standards section of this chapter. In addition, a PCP must be accessible 24 hours per day, 7 days a week.

Each PCP must follow all periodicity schedules, use appropriate health assessments or documentation, and maintain an individual medical record for all patients. In addition, any PCP providing care to Medicaid members up to age 18 must participate in the Vaccines for Children (VFC) program.

The PCP is responsible for assessing the mental stability of their members and should direct care to behavioral health care services as appropriate. The PCP has a right to inform the member how to access mental health services and coordinate access to these services, when necessary.

The PCP is responsible for communicating effectively with members by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with Low English Proficiency (also known as LEP) when needed by the member as outlined in the **Cultural Competency & Nondiscrimination** chapter of this manual.

## Advance Directives

Advance Directives are written documents designed to allow competent patients the opportunity to guide future health care decisions if they are unable to participate directly in medical decision making. The Patient Self-Determination Act requires that patients be informed about their right to participate in health care decisions, including their right to have an advance directive.

Our member handbook contains information concerning advance directives. Providers must document in a prominent part of a member's current medical record the presence or not of an executed advance directive and follow all applicable state and federal laws regarding the execution of these directives.

Each state has different regulations for the use of advance directives. Two common forms used for advance directives are the Living Will and the Durable Power of Attorney for Health Care Decisions. We require participating providers to document discussion of a living will or advance directive.

If you require more information regarding advance directives, there are several sources of information available in the Appendix under Advance Directives.

## Employee Screening Standards

Participating provider offices agree, under their contract with us, that all providers, employees, owners, agents, and managing partners within the provider office, prior to being hired and monthly thereafter, must be screened using PA MediCheck (and any other applicable state exclusion lists), the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on System for Award Management (SAM) databases, Social Security Administration's Death Master File, and the National Plan and Provider Enumeration System (NPPES). It is the responsibility of the employer to perform sanction screenings on all employees within the Fraud, Waste & Abuse safeguards of participation in the Federal and State government programs.

## Provider Office Practice Standards

On the following pages, you will find a table listing our mandatory and recommended Provider Office Standards. Please first note the Mandatory and Recommended Emergency Procedures.

### Mandatory Standards

Staff members who are licensed or administer patient care must be CPR-trained and available during patient hours.

Emergency equipment and supplies must be present and appropriately maintained.

All primary care and specialty practices that administer injectable medications with a potential for anaphylactic reaction must maintain adrenaline or epinephrine, and an appropriate means and qualified staff to administer mechanical ventilation (e.g., ambu bag or resuscitation mouthpiece). Exceptions include offices connected to hospitals where CPR/code teams respond to medical emergencies.

Staff must be able to identify who is responsible and describe the frequency with which emergency supplies are checked for availability

and expiration. Offices must schedule supply checks as a routine office procedure rather than as optional or random events.

Offices that perform stress tests must have a defibrillator. At minimum, there should be documentation of quarterly inspection.

For offices that have a defibrillator, the staff must be able to produce a record of daily defibrillator checks and communicate that staff have been trained on proper use of the equipment.

Other equipment and supplies should be available for practice location, specialty, patient population/ environment and accessibility to advanced medical care.

If the practice performs cardiac stress tests, the following must be available:

- Calibrated defibrillator
- Banyan kit or Nitroglycerin
- IV Furosemide (Lasix)
- 50% Glucose
- Sodium bicarbonate
- Lidocaine
- Atropine
- Epinephrine (Adrenaline)
- IV setup
- Oxygen equipment
- Operating manuals

Operating manuals for equipment such as EKGs must be available, and the equipment must be maintained per the manual.

## Recommended Emergency Procedures

Recommended emergency procedures include the following:

- There should be written or verbal emergency procedures.
- There should be periodic training for staff in emergency procedures.
- The practice should have oxygen available, and personnel trained to administer it.

## Office Practice Standards

The table shown below provides an overview of Office Practice Standards used by our provider network.

| Office Practice Standards | | |
|---|---|---|
| **Standards** | **Mandatory Requirements** | **Recommended Standards** |
| **Infection Control** | Infectious material is separated from other trash and disposed of appropriately.<br><br>Medical instruments used on patients are disposable or properly disinfected and/or sterilized after each use.<br><br>Needles and sharps are disposed of directly into rigid, sealed container(s) that cannot be pierced and are properly labeled. | Standard precautions are reviewed with staff and documented annually.<br><br>The practice site has an OSHA manual.<br><br>Hand washing facilities or antiseptic hand sanitizers are available in each exam room. |

| Office Practice Standards | | |
|---|---|---|
| **Standards** | **Mandatory Requirements** | **Recommended Standards** |
| **Medication Management** | Pharmaceuticals, including samples and needles/syringes, are stored in a secure location and away from patient access.<br><br>Controlled substances are in spaces with access restricted to authorized individuals.<br><br>A dispensing log is maintained for controlled substances.<br><br>Expiration dates of all medications, including vaccines and samples, are checked on a regular basis.<br><br>Prescription pads are controlled and kept secure from unauthorized use. | Expired items are disposed of appropriately.<br><br>There is a separate refrigerated area for medications.<br><br>Refrigerator temperatures are logged daily. |
| **Fire Safety** | Fire extinguishers are appropriately identified and properly maintained.<br><br>Exits are clearly marked and are unobstructed. | There are functioning smoke detectors and/or building alarms. |
| **Office Layout & Design** | The physical layout safeguards confidentiality of patient information.<br><br>Patient treatment rooms are designed to safeguard patient privacy.<br><br>There is one exam room per practitioner seeing patients at any given time. | There is adequate seating in the reception area.<br><br>Patient education materials are available.<br><br>The practice site is clean, well maintained, uncluttered, well-lit, and free of danger areas. |
| **Physical Accessibility** | The office meets the minimum standards of accessibility for those individuals with physical disabilities.<br><br>Or there are reasonable alternatives to accommodate those members with disabilities.<br><br>Accommodations include home visits, access to other sites, additional bathroom facilities, portable bathroom facilities, other as approved by the Credentialing Committee.<br><br>Or the office has proof of ADA Title III exemption (U.S. Department of Justice 1-800-514-0301) | N/A |

| Office Practice Standards | | |
|---|---|---|
| **Standards** | **Mandatory Requirements** | **Recommended Standards** |
| **Patient Access to Appointments and Medical Advice** | There is 24-hour coverage of the practice by comparably qualified physicians.<br><br>There is a defined system for medical record keeping.<br><br>There is a preventive health recall system to ensure timely member follow-up for preventive screenings. | The practice has standard procedures regarding scheduling appointments. (see "Access and Appointment Standards" in this chapter)<br><br>The practice has a standard for a maximum patient load of 6 per hour, per provider.<br><br>There are written and/or verbal guidelines for telephone answering.<br><br>There is a recall system for missed appointments to include documentation in the medical record of 3 outreaches, 2 of which must be written notices. |
| **Written Key Policies and Procedures** | There are written key policies and procedures for patient confidentiality and release of patient information. | N/A |

These standards are to be used in conjunction with the guidelines for the Pennsylvania Site Visit Protocol, which were developed in coordination with the Pennsylvania Medical Society.

## Preventive Care and Clinical Guidelines

All participating providers are expected to follow preventive health guidelines by taking an active role in the ongoing management of member care, including appropriate management of members with chronic conditions. Providers are also responsible for ensuring timely and age-appropriate preventive screenings as well as continuity and coordination of care across specialties and care settings.

Our Quality Management Committee periodically reviews preventive care standards and clinical guidelines for members and approves/updates them according to the most current guidelines published by nationally recognized medical and professional societies. **Preventive care** and **clinical care guidelines** are available on our website.

Provider offices without internet access, or those that need extra copies of the guidelines, can call us at 1-888-991-9023. The copies will be printed out and mailed to the requesting provider office.

## Conscience Rights

We respect the conscience rights of individual providers and provider organizations if these conscience rights are made known to us in advance and comply with the current Pennsylvania laws prohibiting discrimination based on the refusal or willingness to provide health care services on moral or religious grounds.

To provide options to our members, the provider will contact our Utilization Management department to arrange for alternative care for the member. Utilization Management will work with Network Management to identify an alternative provider who can offer the care to the member.

## Reportable Conditions – PA-NEDSS

As a reminder, all hospitals, laboratories, providers, and public health staff are required by law to report certain conditions to the Commonwealth of Pennsylvania's Department of Health (PA DOH). This requirement is outlined in Chapter 27 (Communicable and Noncommunicable Diseases) of the Pennsylvania Code (28 Pa. Code § 27.1 et seq) and on its 2003 addendum (33 Pa.B. 2439, Electronic Disease Surveillance System), located on the official Pennsylvania Code website at **pabulletin.com/secure/**.

Providers must report the required diseases/conditions to the PA DOH through Pennsylvania's version of the National Electronic Disease Surveillance System, known as PA-NEDSS. Please note that first-time users of PA-NEDSS must register on their website at **nedss.state.pa.us/nedss/** to use the reporting tool.

*Note: If you are a public health staff member (as defined by PA DOH), you and your supervisor must complete the PA-NEDSS Authorization Request Form to obtain access to PA-NEDSS. Contact the PA-NEDSS Help Desk at 717-783-9171 or via email at* **ra-dhnedss@pa.gov** *for the appropriate version of this form.*

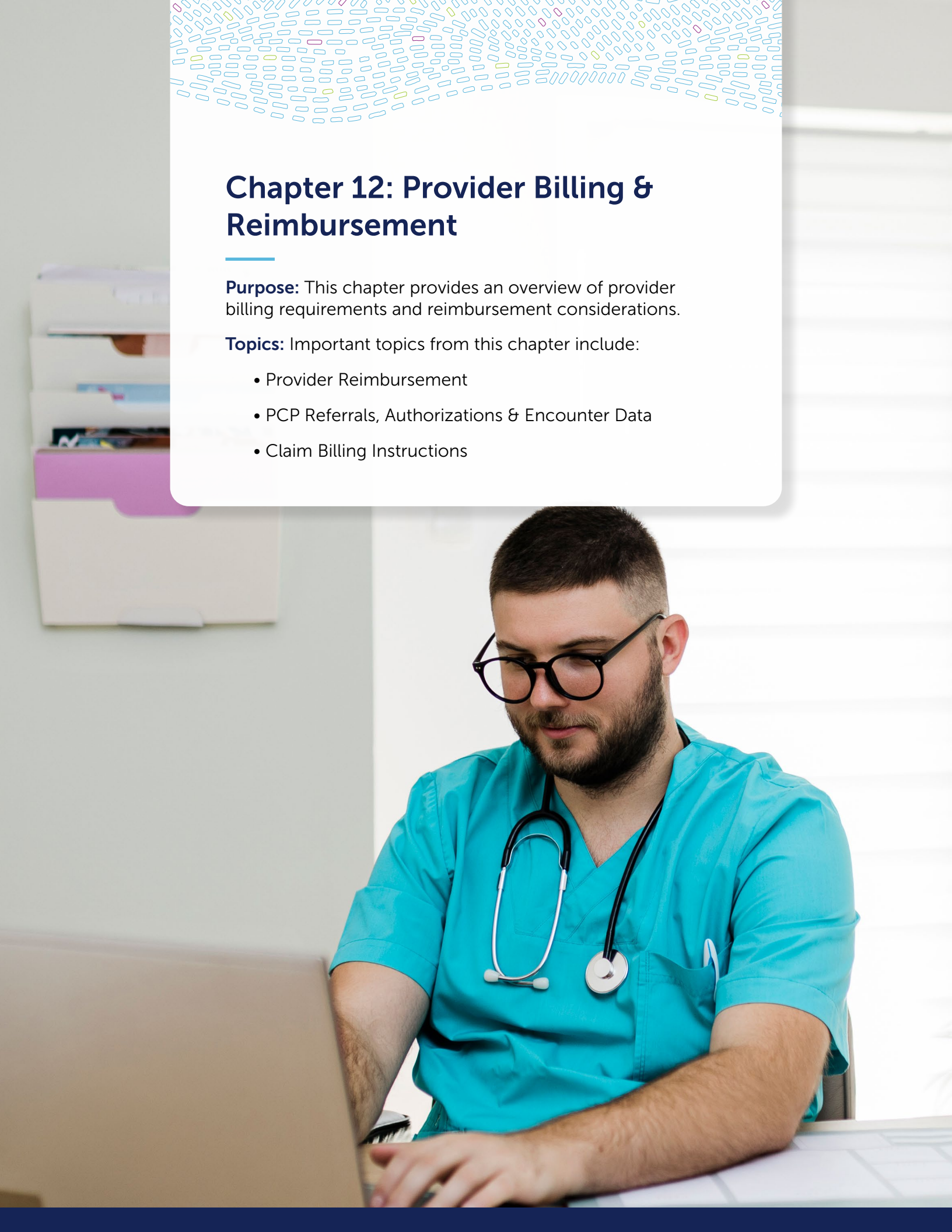
Please visit the **Appendix** for additional PA-NEDSS resources.

# Chapter 12: Provider Billing & Reimbursement

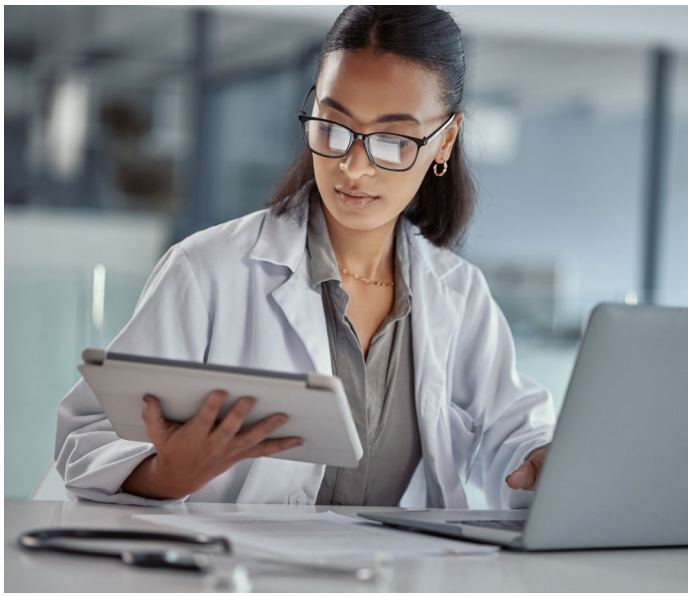
**Purpose:** This chapter provides an overview of provider billing requirements and reimbursement considerations.

**Topics:** Important topics from this chapter include:

- Provider Reimbursement
- PCP Referrals, Authorizations & Encounter Data
- Claim Billing Instructions



# Overview



We provide services to individuals who are eligible for benefits through our participation in the HealthChoices Medical Assistance program (Jefferson Health Plans EverWell), Medicare Advantage (Jefferson Health Plans Medicare Advantage), the Children's Health Insurance Program (Jefferson Health Plans CHIP) and the Pennsylvania marketplace (Jefferson Health Plans Individual and Family plans).

Payments will be made for all of our products at the lesser of billed charges or per the payment terms indicated in the provider's individual contract. In either case, we consider such remittance to be payment in full.

*Note: Do not bill Jefferson Health Plans EverWell members for services.*

Jefferson Health Plans EverWell members are never responsible for paying participating providers any amount for covered medical services, other than approved copayment amounts as part of the member's benefit package.

If you are participating in the Medical Assistance Program you may NOT seek reimbursement from the member for a balance due unless it is for a non-compensable service or one beyond his/her covered limits and the member is told by the provider, in writing, BEFORE the service is rendered.

If the member is dually eligible (Medicare/Medicaid) or has other insurance coverage, and the claim is for a coinsurance or deductible amount, please be aware we reimburse these amounts up to the applicable contracted or statutory limits.

# Provider Reimbursement

The following sections provide an overview and guidelines for the reimbursement methods and requirements utilized by us.

## Fee-for-Service Providers

All specialists and PCPs on a fee-for-service agreement are compensated based on the then prevailing or contracted rates. For Jefferson Health Plans CHIP, this includes reimbursement for childhood immunizations. Examples of fee schedules are available on request through the Provider Services Helpline (see **Chapter 1** for **Contact Information**). CMS Medicare fee schedule payments are final and will not be adjusted or impacted by traditional Medicare quality performance or pay for performance adjustments. This rule applies to all lines of business with reimbursement methodology based on the CMS fee schedule. Providers must follow CMS published billing requirements and specifications when submitting claims and must include all claim information required by traditional Medicare. ALL services must be reported to us on a CMS-1500 form or via electronic submission in an ASC X12N-837P format, using current HIPAA-standard coding. All facility services must be reported to us on a UB-04 form.

### Additional Compensation for PCPs (Medicaid Only)

For the Jefferson Health Plans EverWell program, certain immunizations, pediatric preventive services and hospital visits to newborns are eligible for additional compensation to primary care physicians without further authorization from us.

Reimbursement for these immunizations and hospital visits is based on the completion and submission of the following form(s):

- EPSDT Encounter: Providers should report the appropriate level Evaluation and Management CPT code, plus CPT code EP Modifier and all immunization CPT codes to properly report an EPSDT claim. Without this required coding, Encounters (claim services) will not be able to be reported to the Department of Human Services (DHS). If the encounter is unable to be reported, the provider may be subject to retraction of payments made for these services.
- Administration of immunizations when participating in the Vaccines for Children Program.

### Missed Appointments (Medicaid Only)

According to Pennsylvania Department of Human Services Medical Assistance Bulletin 99-10-14, a provider is not permitted to bill a member for a missed appointment. According to the Centers for Medicare & Medicaid Services (CMS), a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall cost of doing business. As such, it is included in the MA rate and providers may not impose separate charges on Medicaid recipients. State Medicaid programs, including Pennsylvania's MA Program, must comply with the CMS policy on this subject; therefore, MA enrolled providers who render services to MA recipients may not bill recipients for missed appointments.

## PCP Referrals, Authorizations & Encounter Data

The following sections provide guidelines for referring members to specialist services, obtaining authorization for those services when necessary and accurately recording member encounters.

### PCP Referrals: Medicaid and CHIP

PCP referrals are not required for Jefferson Health Plans EverWell and Jefferson Health Plans CHIP members for any service, including influenza and pneumococcal vaccines and women's routine and preventive services (e.g., mammography screenings). It is extremely important for specialists to keep the member's assigned PCP informed of all care they are rendering to their member, so the PCP has the opportunity to best manage the member going forward. Having all current procedure and outcome information will be critical to the approach the PCP takes in managing the member.

It is the responsibility of the rendering provider to verify eligibility prior to rendering care to a Jefferson Health Plans EverWell or Jefferson Health Plans CHIP member and to verify authorization requirements prior to rendering any procedure.

The PCP still drives member care. When coordinating care, the PCP should direct the member to a specialist who they believe can assist with the care needed. We realize that PCPs may occasionally need to direct members to a non-participating provider for some need or service not available through a participating provider. However, we require prior authorization before services can be rendered by a non-participating provider. If the PCP does not obtain prior authorization, reimbursement will be denied to the specialist.

If a member is not eligible with Jefferson Health Plans EverWell or Jefferson Health Plans CHIP on the date of service, the physician will not be paid. To be sure, log on to our **Provider Portal** or call us (see **Chapter 1** for **Contact Information**) before the service is rendered.

The specialist is able to provide consultation, and any additional services required to treat the condition for which the member was directed. If the additional services being ordered require prior authorization, it is the specialist's responsibility to obtain the prior authorization.

If the specialist identifies the need to direct the member to another specialist, the PCP should be contacted to maintain a role in the member's care and should always be given the opportunity to communicate with all treating specialists related to the care of the member.

In accordance with Pennsylvania law and the Department of Human Services requirements, we will maintain procedures by which a member with a life-threatening degenerative or disabling disease or condition shall, upon request, receive an evaluation to determine if the member qualifies to select a specialist to act as his/her Primary Care Physician. This evaluation will include a written letter of medical necessity from the specialist and a determination by the Medical Director. If the specialist is designated as the primary care provider, he/she must be credentialed as a PCP.

### PCP Referrals: Medicare Advantage and Individual and Family Plans

PCP referrals are not required for our Jefferson Health Plans Medicare Advantage or Individual and Family plans products. It is extremely important for specialists to keep the member's PCP informed of the care they are rendering, so the PCP has the opportunity to best manage the member going forward. Having all current procedure and outcome information will be critical to the approach the PCP takes in managing the member.

The PCP should coordinate care between the member and the specialist(s) who they believe can assist with the care needed. We realize that PCPs may occasionally need to direct members to a non-participating provider for some need or service not available through a participating provider. In most cases, we require prior authorization before services can be rendered by a non-participating provider.

Our Jefferson Health Plans Medicare and Jefferson Health Plans Individual and Family Plans PPO products offer our members the convenience of receiving services from a non-participating provider. In these instances, our in-network prior authorization requirements will apply. If the PCP does not obtain the appropriate prior authorization, reimbursement will be denied to the specialist.

The specialist is able to provide consultation, and any additional services required to treat the condition for which the member was directed. If the additional services being ordered require prior authorization it is the specialist's responsibility to obtain the prior authorization.

It is the responsibility of the rendering provider to verify eligibility prior to rendering care to a Medicare member and to verify authorization requirements prior to rendering any procedure.

If a member is not eligible with Jefferson Health Plans on the date of service, the physician will not be paid. To be sure, log on to our **Provider Portal** or call us (see **Chapter 1** for **Contact Information**) before the service is rendered.

## Member Encounters

Our PCPs, specialists, Ambulatory Surgical Centers, ancillary and allied health providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with our member(s). All providers must submit this form within 180 days following the encounter date or payment will be denied. PCPs must report encounter data associated with EPSDT screens of Medicaid members within 180 days from the date of service.

# Claim Billing Instructions

We are required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure that the required data is captured, and that claims are processed in an accurate, timely manner.

## Important Note for Medicaid Claims

We are required to submit to the Pennsylvania Department of Human Services (DHS), the Commonwealth's department responsible for administering Medicaid, all necessary data that characterizes the context and purpose of each encounter between a Medicaid enrollee and a physician/practitioner, supplier or other provider. State regulation requires services to Medical Assistance recipients be rendered by providers participating in Medicaid, except in emergent or urgent situations. It is the responsibility of all providers enrolled in Medicaid to ensure that the information they supply to DHS (e.g., address information) is correct and kept up to date. DHS uses encounter data to develop risk-adjusted ratings that are tied to reimbursement for Managed Care Organizations (MCO). A provider's failure to submit complete, accurate and timely encounter data to us as required may result in actions such as payment delay or no payment at all, as well as possible exclusion from the network.

## Billing Requirements and Guidelines

One of our goals is to ensure timely and accurate claims processing. To that end, this section is intended to provide guidance to Provider Billing Offices so that complete and precise medical claim filing for payment consideration can be accomplished. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

Claim (encounter) data, specifically the diagnosis and treatment codes, is used by DHS to develop a risk-adjusted reimbursement rate. DHS will reimburse Medicaid MCOs according to the level of illness experienced by and service rendered to their members. As an extension, reimbursements to providers from Medicaid Managed Care Organizations will become dependent upon the quality of the data used in this reimbursement methodology. A provider's failure to submit to us complete and timely encounter data, coded to the highest level of specificity, will have costly long-term effects. It is important that providers file all claims and encounters as required. Failure to do so could result in possible exclusion from the network.

## Preventable Serious Adverse Events

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

## Initial Claim Submission Procedures

We have specific, established requirements for filing a notice of claim. These requirements include that the notice of a claim be valid and complete, furnished within a prescribed time, and be delivered to the correct business address. Failure to comply with any of these requirements shall constitute a bar to filing a claim and shall preclude payment. To be accepted as a valid claim, the submission must:

- Be submitted on a standard current version of a CMS-1500, CMS-1450/UB-04 or in the ANSI X12-837 electronic formats (current version). Claim forms should not be photocopied versions. Paper claims must be submitted on original Red and White forms.
- Contain appropriate, current information in all required fields
- Be a claim for a plan member eligible at the time of service
- Be a claim for a provider properly established on Jefferson Health Plans' processing system for the time period and location (site) billed
- Be an original bill

- Contain correct current coding, including but not limited to CPT, HCPCS, modifier, DRG, Revenue and ICD-10 codes
- Not be altered by handwritten additions or corrections to procedure/service codes and/or charges
- Be printed with dark enough ink to be electronically imaged if submitted as a paper claim
- Be received within 180 days from the date of service as measured by the date stamp applied by a Health Plan representative who has agreed to and has the authority to accept claims at our business address
- or by the system receipt date if filed as a paper claim through the correct claim post office box
- or by system receipt date after passing via an electronic data interchange gateway and through our claim validation front-end editing
- For providers reimbursed on a CMS Medicare payment methodology (e.g., OPPS, IPPS, CMS Fee Schedules), providers must follow CMS' published billing requirements and specifications when submitting claims to us. In addition to the requirements set forth in this Provider Manual, the Provider must also include all claims information required by traditional Medicare under the provider's applicable contracted payment methodology.

## Provider Numbers and Set Up

All providers billing for services, whether participating or non-participating, must be established on the Jefferson Health Plans processing system with effective dates coinciding with the dates of services billed.

## Non-Participating Providers

Non-participating providers, whether rendering emergency services or prior authorized and approved treatment, must provide the following information to be established on our system:

- W-9 tax form
- Pennsylvania Medicaid Assistance Identification Number (in-state, Jefferson Health Plans EverWell providers only)
- State Medical License Number and Expiration Date
- NPI (National Provider Identification) Number
- Provider Specialty
- Specialist should declare their specialty
- Facility
  - Allied Health Provider
  - Ancillary Health Care Provider (Home Health, DME, Transportation)

*Note: Non-participating provider services (except for emergency services) require prior authorization by calling our Inpatient Services or Outpatient Services (see* **Chapter 1** *for* **Contact Information***).*

To be established as a non-participating provider, please send the required information listed above to:

> **providerdata@jeffersonhealthplans.com**
>
> Or
>
> Fax to:
> 215-967-4486
> Attn: Provider Data Maintenance Team

## Participating Providers

Participating providers must be contracted and credentialed by us. For electronic claim submission, providers must bill with their individual and billing NPI numbers or their claims will be denied.

## Claim Mailing Instructions

For paper claims, Health Plan (Medicaid, CHIP, Medicare (**HMO-POS and HMO SNP products**) and Individual and Family plans) claims should be mailed to:

> Jefferson Health Plans
> P.O. Box 21228
> Tampa, FL 33622

For Jefferson Health Plans (**PA Medicare PPO products**) claims should be mailed to:

> Jefferson Health Plans
> P.O. Box 21247
> Tampa, FL 33622

For Jefferson Health Plans (**NJ Medicare PPO products**) claims should be mailed to:

> Jefferson Health Plans/Partners Insurance Company of New Jersey
> P.O. Box 21367
> Tampa, FL 33622

## Medicaid Home Health Providers

- Obtain an authorization for the service.
- Record EVV hours and minutes in HHAeXchange with the correct modifiers if applicable.
- Create and submit a claim using HHAeXchange. If provider has opted to use another platform for billing, the provider is responsible for sending claim data to HHAeXchange and Sandata so the MCO is prepared for encounter filing.
- Submit appropriate provider type and specialties-based on DHS EVV requirements. Check DHS' PROMISe system to confirm what is the appropriate provider type and specialty for submissions.
- Document other insurance information in the HHAeXchange Secondary Screen, inclusive of non-covered information from the primary insurance.
- For Claim reconsideration appeals, send documentation to support the appeal (i.e. primary EOP, Denial and Exhaustion Letters) in the **Provider Portal**.

## Claim Filing Deadlines

We allow 180 calendar days from the date of service or discharge date to submit and have accepted a valid initial claim.

A claim must be accepted as valid (as proven by entry into our claims processing system and assignment of a claim control number) to be considered filed. Paper claim submissions that cannot be entered into the claim processing system because of invalid member, provider or coding information are returned to the provider with a rejection notice (form letter or insert) explaining the reason for rejection.

Electronic claim submissions are rejected on electronic submission/error reports. The submission/error report(s) a provider's office receives depends on the billing service and/or electronic interchange vendor used. Because we currently use Smart Data Solutions (SDS) as the gateway for electronic submissions from other billing services and/or electronic interchange vendors, an acknowledgement of all claims accepted through SDS and submitted to us is generated, as well as a first level rejection report of those claims not passing SDS's edits. Once the edits are passed, our system edits for member, provider and coding information generate a second level of acceptance and/or error reports. Providers should check with their billing service and/or electronic interchange vendor to fully understand how our specific information is being provided.

During the 180-calendar day initial filing period, a provider may resubmit a non-accepted (invalid or EDI rejected) claim as often as is necessary to have it accepted. It is the provider's responsibility to ensure their claims are accepted within the 180-day filing timeframe.

Once an initial claim is accepted, any subsequent (repeat) filing, regardless of whether it is paper or electronic, will deny as a duplicate filing. The initial claim, however, will be processed.

- If the claim does not appear on an Explanation of Payment (EOP) within 45 calendar days of submission as paid, denied or as a duplicate of a claim already under review, and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.

Claim status can be confirmed by accessing our **Provider Portal** or by calling the Provider Services Helpline at 1-888-991-9023. An inquiry does not extend or suspend the timely filing requirement.

If, after resubmission, another 45 calendar days pass without the claim appearing on the Explanation of Payment (even as a duplicate denial), the provider should contact us to discuss what could be preventing the claim from being accepted.

Claims that have been adjudicated (paid or denied) cannot currently be re-filed as though they were initial, unprocessed claims. Re-filing a previously adjudicated claim will cause automatic denial as a duplicate submission. To contest an incorrectly processed claim, see the Claims Inquiries and Reconsiderations section below.

## Filing Period Exceptions

The only exceptions to the 180-calendar day filing period are:

- If the delay was caused by a third-party resource filing. Third-party resource claims must be submitted within 60 calendar days of the initial determination notification from the primary carrier. This includes submitting a primary carrier EOP to us for coordination of benefits.
- If our Enrollment department verifies a problem determining a member's eligibility.
- Non-participating Medicare providers must submit claims within 365 days of the date of service.

## Claim Form Filing Requirements

Claim form completion requirements for both CMS-1500 and UB-04 forms are displayed later in this chapter. Each field is listed by number and includes a description of the data needed along with an "**R**", "**C**" or "**O**" field code.

**"R" (required).** If the field is coded "R" (required) the data must be completed on every form submitted. If the field is not complete or contains invalid data, the claim will not be considered for payment.

**"C" (conditional).** If a field is coded "C" (conditional), the data is required only for claims submissions where the field is directly related to the billed services for that record type. However, if the information is not included but is applicable to the billed services, the claim will not be considered for payment. Only claims completed as outlined will be eligible for payment consideration.

**"O" (optional).** A field coded "O" is optional.

Common Reasons for Claim Rejections or Denials include but are not limited to:

- **Incorrect Member Identification number.** Do not use the Medicaid ACCESS card number when submitting claims for MA members. Use of this number will cause a claim rejection. Until DHS has assigned a permanent Medical Assistance number, newborn claims will be denied.
- **Incorrect Provider Identification number.** For electronic and paper claims, a provider must use both the individual and the billing NPI number. If these numbers have not been established in our processing system it may cause a provider to appear as non-participating, thus requiring authorization for services. Without an authorization, or a valid legacy provider number, all claims will be denied.
- **Authorization and claim service dates do not match.** Providers are responsible for communicating all service dates, beginning/admission through ending/discharge. If the scheduled service date is canceled or

rescheduled, providers must call Inpatient Services or Outpatient Services to update the authorization to reflect the change. Any service dates not included in the authorization will be denied.

- **Invalid procedure and/or diagnosis codes.** Claims must be coded with the most current procedure and diagnosis codes at the highest level of specificity. Unless claims are properly and completely coded, they will be rejected if invalid or denied if obsolete.
- **Unlisted Procedure Codes.** Unlisted and miscellaneous codes do not provide the description of a specific procedure or service. We require that the service reported by the unlisted procedure code be identified when clinical information is provided.
  - For any unlisted procedure codes, please be sure to attach the following supporting documentation:
    - Cover letter that is concise and outlines the procedure / service being reported with the unlisted procedure code.
    - Operative report or office notes that describe services performed that support medical necessity of the procedure.
    - Determine an appropriate comparable procedure and identify differences between it and the new procedure you have performed. Include these differences in your cover letter.

Providers should consider what type of information would best help us understand what exactly is being billed. If we have any further questions about the service or item, additional information may be requested.

Examples of unlisted procedure codes:

- 21299 Unlisted craniofacial and maxillofacial procedure
- 37799 Unlisted procedure, vascular surgery

Be sure to report the appropriate unlisted code for the category/type of procedure performed. For example, report an unlisted laparoscopy procedure of the esophagus with *43289 Unlisted laparoscopy procedure, esophagus*, **not** *43499 Unlisted procedure, esophagus*.

- **Directing care to non-participating providers**. Except for emergency services and allotted out-of-network benefits for our Jefferson Health Plans Medicare and Individual and Family Plans PPO products, all non-participating providers require prior authorization. (Please call our Inpatient and Ancillary Services.) Without proper authorization, non-participating provider claims will be denied.
- **Billing us as primary when other insurance exists.** Providers must verify coverage every time a member is seen for services. We can be contacted to review other insurance information on file. If we are billed before the primary carrier has made a determination, the claim will be denied.
- **Explanation of Payments/Benefits (EOP/EOB) from primary insurers not submitted for secondary payment.** We will only pay up to our allowable fee schedule or contracted rate, minus what the primary payer did or would have paid for example deductibles, co-payments, or co-insurance as demonstrated on the EOP attachment. The claim will be denied until the required EOP information is submitted. The primary EOP must be submitted to us within 60 days of being issued.
- **Member benefit limitation has been exceeded.** Certain benefit packages have limitation to the number of services allowed. We will only pay for those services covered under their respective benefit package and will only reimburse the allowable portion of the claim, i.e., coinsurance and deductible.

## Electronic Data Interchange (EDI)

We offer providers the speed, convenience and lower administrative costs of electronic claims filing or Electronic Data Interchange (EDI). EDI performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs. Effective March 14th, 2024, the plan uses Smart Data Solutions (SDS) as our claim's clearinghouse.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs.
  - EDI eliminates the need for most paper claim submissions.
- Faster transaction time for claims submitted electronically.
  - An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received by us. Many electronically submitted claims, because of the "clean data" embedded within the claim, can be auto-adjudicated.
- Validation of data elements on the claim form.
  - By the time a claim is successfully received electronically, information needed for processing has been pre-screened for required elements and, if passed, will be accepted as submitted. This reduces the chance of data entry errors that occur when completing paper claim forms.

For all claims (837 Institutional and 837 Professional) submitted electronically through the SDS clearinghouse, we can electronically return detailed status information through SDS.

The status message will show which claims were accepted, rejected and/or pending, and provide the amount paid on the submitted claim once it has been finalized. It is the Provider's responsibility to monitor all reports of electronic submissions to assure that claims are accepted. Please contact your billing software vendor for additional information regarding all available reports.

To take advantage of EDI, providers should contact their billing software vendor and request that our claims be submitted directly through the SDS claims clearinghouse. Or, billing software vendors may be able to submit claims through their current clearinghouse and request forwarding to SDS. (Providers who are already SDS submitters, but who do not receive SDS claim status reports, should contact their software vendor.) If you require assistance with electronic filing contact us at **edi@jeffersonhealthplans.com**.

## EDI Claim Filing Requirements

Our Payor ID Number is #80142 for our Medicaid, CHIP, Medicare Advantage (HMO-POS and HMO SNP products) and Individual and Family Plans.

Our Payor ID Number is RP099 for our Pennsylvania Medicare Advantage PPO product.

Our Payor ID Number NJ099 for our New Jersey Medicare Advantage PPO product.

Claims transmitted electronically must contain all of the required data elements identified within the 837 (Professional and Institutional) Claim Filing Companion Guide found on our **HIPAA Connect** webpage. SDS or any other EDI clearinghouse or vendor may enforce additional, allowable data record requirements.

To send claims electronically to us, all EDI claims must be forwarded through SDS. This can be completed through any EDI clearinghouse or vendor.

SDS validates against HIPAA-required Transaction Code Set edits, allowable SDS proprietary specifications, and allowable Health Plan specific requirements. Claims not meeting the required HIPAA or SDS edits are immediately rejected and sent back to the sender via the RPT 05 Provider Daily Statistics report. This report details the rejected claims and the error explanation. Claim records that do not pass these required edits are considered invalid and will be rejected as never received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

SDS accepted claims are tracked on the RPT04 Daily Acceptance Report by the provider. This is a list of claims passed to Jefferson Health Plans but not necessarily accepted by us. If there are providers or members not found, or other allowable edits due to invalid claim data, these claims may be rejected by us.

Providers should pay close attention to the RPT11 Unprocessed Claims Report because it is the notification report that identifies claims that are not accepted in our system. This report is a critical part of the workflow in that it contains the reason these claims were not accepted. Claim records that do not pass our required edits are considered invalid and will be rejected as never received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Providers are responsible for verification that EDI claims are accepted by SDS and by us. Acknowledgement reports, claim acceptance reports, error reports for rejected claims, and unprocessed claim reports that are received from SDS directly or other contracted billing or gateway vendors must be reviewed and validated against transmittal records daily.

If a provider is submitting claims through a billing company or single source (such as a hospital EDI Unit handling all specialty department billing), and that billing company or single source is combining all records into one daily file when sending electronic submissions to SDS, any acknowledgement or rejection reports may also be combined. It is the responsibility of the billing company or single source to separate those errors and work them with each respective provider or medical department. Our EDI team can see all errors that are reported on the RO59 Unprocessed Claim Report and that the rejection occurred but can do no more to help with the flow of information at the provider's end.

## EDI Exclusions

Certain claims may not be submitted through electronic billing. The exclusions fall into two categories:

- **Excluded Providers**
  Providers or vendors who are not contracted with SDS (Their claims are not transmitted through SDS).
- **Excluded Claims**
  Claims requiring supportive documentation or attachments such as invoices (until further notice, these claims must be submitted on paper).

## Early Periodic Screening, Diagnosis & Treatment Reporting (Medicaid)

Early Periodic Screening, Diagnosis and Treatment (EPSDT) reports are filed for all members from the time of birth until 21 years of age. Completion of a claim form documenting any encounter, whether the service is prepaid (capitated) or fee-for-service, is a mandatory requirement, not an option.

The PCP of a member under the age of 21 years should perform and report EPSDT screens and appropriate immunizations or make arrangements for EPSDT screens to be performed elsewhere. These screens must be in accordance with the schedule developed by DHS and recommended by the American Academy of Pediatrics. As per the EPSDT guidelines, providers must advise members to obtain the appropriate dental services, contact our Enhanced Member Support Unit (215-845-4797) to coordinate dental appointments and document the dental referral on the claim.

Our providers may use the CMS-1500 form or file an electronic claim to report EPSDT activity. Dental referrals (YD) should be keyed in the 10D field of the claim. We rely on receipt of thoroughly completed CMS-1500 forms to obtain useful aggregate information about overall delivery of preventive care.

To properly report an EPSDT claim, PCPs should report:

- The appropriate level Evaluation and Management CPT code with the modifier EP, plus CPT code EP Modifier.
- Age-Appropriate Evaluation and Management Codes (as listed on the current EPSDT Periodicity Schedule and Coding Matrix).

For the latest EPSDT Periodicity Schedule and Coding Matrix, please refer to the most recent DHS bulletin or visit the **EPSDT/Bright Futures** page of our website.

When making a dental referral, a provider must submit a remark code of YD on the claims. If submitting a CMS-1500 form, the YD should be placed in field 10D. If submitting electronically, the YD code is placed in 2300NET01.

All EPSDT documentation is required as a permanent part of the member's medical record.

## Benefits for Pregnant members (Medicaid Only)

Certain limitations on the number of services or applicability of copayments do not affect pregnant members. Members who are confirmed to be pregnant are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy, and until 12-months postpartum. These services include expanded nutritional counseling and smoking cessation services. However, services which are not covered under a pregnant woman's HealthChoices Benefit Package (HCBP) are also NOT covered, even while pregnant. For a fuller description of the benefits for pregnant members, please see **Benefits During and After Pregnancy** in **Chapter 4**.

To ensure that a claim is processed without a service limitation, providers must bill with a pregnancy indicator on the claim.

*Notes on Copayments: Copayments for services are summarized in the benefits chapters. Services may not be denied to any Medical Assistance recipient on the basis of an inability to collect a copay at the time of service.*

Copayments that are due but not paid should be indicated on the claims as follows:

| Copayments That Are Due (But Not Paid) | |
|---|---|
| **CMS-1500** | Box 24H code 11 |
| **UB92/UB04** | Condition code/indicator, Y3 |
| **837-I** | 2300 Loop, HI, 01, qualifier BG, data element Y3. The condition code/indicator is Y3. |
| **837-P** | 2300 Loop, NTE 01= ADD and NTE<br>02 = VC11 to indicate copay not collected. |
| **NCPDP** | N/A |

## Physician Administered Drugs and Biologicals

In accordance with the Pennsylvania Department of Human Services Operations Memorandum (#10/2013-012), if a claim type is an 837P or 837I Outpatient, and the payment is based upon a HCPCS code such as a J-code or Q-code, the drug must be submitted with the NDC code along with the units dispensed and NDC quantity. The drug should appear on a single claim line with no other services, and the drug administration billed separately.

For all Health Plan products, Hospitals must follow CMS requirements for billing 340B modifiers under the hospital outpatient prospective payment system. All claims for drugs and biologicals purchased through the federal 340B Discount Drug Program must be billed on a separate claim line with the appropriate 340B modifier. (**Exception- Any provider identified as a 340B covered entity must dispense or administer non-340B purchased gene therapy products unless otherwise approved to Medicaid beneficiaries.)

Hospitals that participate in the 340B Program must maintain documentation in accordance with CMS requirements and comply with applicable *reporting requirements.*

The following condition applies to Cell and Gene therapy for Sickle Cell disease. These therapies are excluded from 340B purchasing.

- Providers must be registered with the Center for International Blood and Marrow Transplant research, and participate in a CMS specific study.
- Depending on the provider's contract with us, the reporting of 340B modifiers may impact fee schedule allowances or be collected for informational purposes only.

### Anesthesia Services

Jefferson Health Plans follows CMS guidelines for the reporting and documentation of Anesthesia services. Please refer to the policy for full details: Policy Bulletin Library.

### Outpatient Services Rendered During an Inpatient Stay

Any outpatient service rendered between the admission and discharge dates of an inpatient stay, whether within the same hospital or separate identifiable hospital, will deny with the exception of service rendered on the admission and/or discharge date. Those specific outpatient services may require additional information or medical record review.

The Plan does not separately reimburse outpatient services that are clinically related to an inpatient admission, including emergency department, observation, laboratory, imaging, and other hospital outpatient services. Payment for these services is considered part of the inpatient reimbursement and is not separately payable, consistent with applicable DHS and CMS billing requirements.

### Emergency Room Visits to Inpatient Stays

Emergency room visits at the same facility that led to an inpatient stay are not payable. Those services are considered included in the DRG payment.

### Family Planning Billing (FP Modifier)

The FP modifier distinguishes family planning services from other medical services. It specifically indicates that a service is primarily for contraception or family planning purposes. This designation is critical for accurate billing and reimbursement, especially in situations where a family planning diagnosis code might not be applicable. The modifier helps clearly identify services related to contraception management, counseling, or other family planning activities differentiating them from unrelated medical procedures.

In cases where an appropriate ICD diagnosis code for contraceptive management is unavailable or not applicable, the FP modifier serves as a means to reflect the intent of the service as family planning.

## Third Party Liability (TPL) – All Lines of Business

Third Party Liability (TPL) exists when another individual, entity, or program is legally responsible for payment of all or part of a member's health care expenses. This includes health insurance providers (such as Medicare and employer-sponsored insurance), Workers' Compensation, automobile insurance, personal injury liability insurance, and other third-party resources.

We use Pennsylvania Department of Human Services (DHS) Third Party Liability Resource information and other available sources as a base for identifying other insurance coverage for all members. If evidence of probable other insurance is identified through secondary claim submission, contact from other carriers, or the member, this information will be recorded in our processing systems and reported to DHS, as required. Providers must report any newly discovered third-party resources or updates to existing coverage.

If a provider receives payment from both Jefferson Health Plans and a primary insurer and an overpayment is identified, the provider is required to return the excess payment to Jefferson Health Plans in accordance with applicable regulatory requirements and must cooperate with recovery efforts. See the Overpayments section for additional information regarding recovery processes.

### TPL Reporting and Investigation Requirements

Investigation of potential other insurance coverage is required prior to payment, except when preventive pediatric care services are involved (not including hospital delivery claims).

If a provider learns of other insurance coverage during service provision that is not reflected in the member's file, or learns that existing coverage is no longer effective, the provider must notify Jefferson Health Plans promptly and should make reasonable efforts to include the member's identification number for the other insurance coverage to support outreach to the primary insurer and accurate updates to the member's coverage record.

Providers must report newly discovered third-party resources or updates to existing coverage by calling the Provider Services Helpline at 1-888-991-9023 or by submitting the primary insurer's Explanation of Benefits (EOB). Information on file is available to providers through the helpline.

### Third Party Liability Recovery and Subrogation

Third Party Liability includes automobile insurance, personal injury protection, and other liability coverage (such as homeowners' or business liability insurance) that may be responsible for payment of medical services related to an accident or injury.

- Providers must bill applicable liability carrier(s) as primary when services are related to an accident or injury.
- Providers should not delay billing medical insurers pending the outcome of a legal settlement or judgment.

If Jefferson Health Plans makes payment for services for which another party is legally responsible, Jefferson Health Plans is responsible for identifying and pursuing recovery from the liable third party in accordance with applicable program requirements, contracts, and state and federal law.

If a provider receives payment from Jefferson Health Plans and a third party for the same services and an overpayment is identified, the provider is required to return the excess payment in accordance with applicable laws and regulations. Providers must cooperate with recovery efforts, including timely repayment of identified overpayments and submission of documentation when requested.

For Jefferson Health Plans EverWell members, the Pennsylvania Department of Human Services (DHS) retains statutory rights of recovery and subrogation for Medicaid-paid services, after Jefferson Health Plans has pursued recovery in accordance with applicable recovery timeframes and program requirements. DHS may assert liens or recovery rights against settlements or judgments in accordance with state and federal law, including in circumstances where recovery is not otherwise obtained.

## Coordination of Benefits – Claim Submission and Billing Order (All Lines of Business)

Coordination of Benefits (COB) establishes the order of payment when a member is covered under more than one health plan and prevents duplicate payment for the same service. When other insurance coverage exists, providers are required to submit claims to the primary payer first (such as Medicare, employer-sponsored insurance, Workers' Compensation, etc.) and obtain a primary insurer's Explanation of Benefits (EOB) before submitting a secondary claim to Jefferson Health Plans.

### Claim Submission Process

- **Submit to the primary insurer first:** Providers must submit the claim to the primary payer for adjudication.
- **Obtain the primary insurer's EOB or EOP:** Providers must obtain and retain documentation from the primary insurer reflecting the claim adjudication and payment determination, such as an Explanation of Benefits (EOB) or Explanation of Payment (EOP), including any applicable cost-sharing (coinsurance, deductible, copayments).

- **Submit secondary claim to Jefferson Health Plans:** After the primary insurer has made a payment determination, providers should submit a secondary claim to Jefferson Health Plans. This secondary claim must include the primary insurer's EOB or EOP as an attachment, as applicable and consistent with HIPAA transaction standards.
- **Adhere to appropriate timelines:** Providers must submit secondary claims within 60 days of the primary payer's EOB paid date. If a claim is submitted after the 60-day period, it may be denied for timely filing.
- **Provider appeals:** Provider appeals must be submitted within 180 days of the denial date for the primary insurer.

### Primary Payer Documentation Submission Requirements

- **Primary Payer Documentation (EOB or EOP):** When submitting secondary claims, providers must attach documentation from the primary insurer reflecting the claim adjudication and payment determination, such as an Explanation of Benefits (EOB) or Explanation of Payment (EOP). Claims submitted without required documentation (EOB, EOP, denial letter, exhaustion of benefits notice, or equivalent primary payer documentation) will be denied for lack of documentation.
- **Incomplete or Incorrect Information:** Claims submitted with incomplete or incorrect primary insurance documentation (such as missing member or provider details, dates of service, billed charges, payment amounts, or denial codes and reasons) will be denied for incomplete primary payer documentation.

## Coordination of Benefits – Payment When Jefferson Health Plans Is Secondary

When a Jefferson Health Plans member is covered by more than one health plan, Jefferson Health Plans coordinates benefits in accordance with applicable federal and state laws, including Medicaid Third Party Liability (TPL) requirements, Medicare Secondary Payer (MSP) rules, and applicable commercial coordination of benefits standards.

When another payer is determined to be primary, providers must submit claims to the primary payer prior to billing Jefferson Health Plans, unless otherwise permitted by law.

### Payment When Jefferson Health Plans is Secondary

When Jefferson Health Plans is the secondary payer, payment will be made up to the lesser of:

- The difference between the applicable Jefferson Health Plans allowable amount and the amount paid by the primary payer; or
- The remaining amount of applicable coinsurance, deductible, or copayment.

In no event will the combined payment from the primary payer and Jefferson Health Plans exceed the applicable Jefferson Health Plans allowable amount for the covered service.

Jefferson Health Plans Medicaid operates as a payer of last resort, and Jefferson Health Plans CHIP, which is a state-regulated program administered by Jefferson Health Plans, coordinates benefits in alignment with applicable Medicaid Third Party Liability (TPL) principles and state CHIP requirements; Medicare Advantage benefits are coordinated in accordance with CMS Medicare Secondary Payer (MSP) rules, and ACA plans coordinate benefits in accordance with applicable federal and state commercial coordination of benefits requirements.

If the primary payer's payment fully satisfies the provider's reimbursement obligation for the covered service (i.e., the provider has been made whole) and no Jefferson Health Plans-recognized payment responsibility remains, no additional payment will be made.

Payment determinations are subject to applicable federal and state law and provider-specific payment requirements, including prospective payment system (PPS) obligations for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), where applicable.

# Member Billing Rules

Providers must comply with applicable federal and state law, program requirements, and Jefferson Health Plans provider contracts when billing members. Member billing obligations vary by line of business.

**General Rule (All Jefferson Health Plans):** Member billing rules depend on the applicable line of business, program requirements, and benefit design.

Providers must:

- Bill other responsible payers first, when applicable.
- Apply all payments before determining any member financial responsibility.
- Bill members only when permitted under the applicable plan, law, and provider contract.
- Not bill members for any remaining balance when both the primary payer and Jefferson Health Plans deny a claim in accordance with applicable requirements.

Member billing is strictly prohibited where federal or state law requires members to be held harmless.

**Jefferson Health Plans EverWell (Medical Assistance) and CHIP:** Jefferson Health Plans EverWell operates as a payer of last resort, and members are generally not responsible for payment of covered medical services. Jefferson Health Plans CHIP, which is a state-regulated program administered by Jefferson Health Plans, follows similar member billing protections in alignment with applicable Medicaid Third Party Liability (TPL) requirements and state regulations.

Providers must not:

- Collect copayments, coinsurance, or deductibles at the time of service when Jefferson Health Plans EverWell or CHIP is secondary.
- Bill members for covered services.
- Deny services based on a member's inability to pay a copayment.

Members may be billed for non-covered services only when the member has been notified in writing and in advance, in accordance with applicable law.

**Paid-in-Full Requirement:** Once the applicable contracted Medicaid allowable amount is satisfied through payment by the primary payer, Jefferson Health Plans, or both, the provider is considered paid in full. No additional amounts may be billed to the member, and any excess amounts collected must be refunded. Billing beyond permitted limits violates Medicaid regulations and Pennsylvania law.

**Medicare and Medicaid Dual-Eligible Member:** Providers may not bill Medicare–Medicaid dual eligible members for Medicare Part A or Part B cost-sharing. Cost-sharing must be billed to the member's assigned Community HealthChoices (CHC) plan.

Medicaid payment of Medicare cost-sharing is limited to the difference between the Medicare payment amount and the applicable contracted Medicaid rate for the service. If the contracted Medicaid rate is lower than the Medicare payment amount, Jefferson Health Plans may not remit payment, and the provider will be considered paid in full.

Participation in the CHC plan's provider network is not required in order to submit claims for Medicare cost-sharing.

**Jefferson Health Plans Medicare Advantage:** Medicare Advantage cost-sharing includes copayments, coinsurance, and deductibles as defined under Medicare rules and the member's benefit plan. Member billing is limited to cost-sharing amounts permitted under applicable federal requirements, benefit design, and provider contract.

**Prohibition on Member Billing (QMB):** Federal law prohibits providers from billing Qualified Medicare Beneficiary (QMB or QMB Plus) members for any Medicare Part A or Part B cost-sharing. Providers must never bill QMB members for Medicare cost-sharing, even if the service is not covered by Medicaid.

*Note: While Jefferson Health Plans Medicare Special (D-SNP) limits enrollment to members with cost-share protection, dual eligible individuals may also be enrolled in other Jefferson Health Plans products.*

**Jefferson Health Plans Individual and Family Plans (ACA):** Members enrolled in Jefferson Health Plans Individual and Family Plans may be billed for applicable copayments, coinsurance, and deductibles in accordance with their benefit plan and provider contract. When Jefferson Health Plans is secondary, member billing is limited to permitted cost-sharing after all other payments have been applied.

**Program-Specific Rules and Exceptions:** The following program-specific rules and exceptions apply to certain Jefferson Health Plans products and supersede general Coordination of Benefits or billing rules where noted.

**Preventive Pediatric Care Exception (Medicaid):** For Jefferson Health Plans EverWell members, preventive pediatric care is subject to special Coordination of Benefit rules.

- For covered preventive pediatric services, Jefferson Health Plans will not require proof that other insurance was billed prior to claim submission solely for coordination of benefits purposes, except for hospital delivery claims.
- When other insurance or third-party liability is not identified at the time services are rendered, claims for covered preventive pediatric services may be submitted directly to Jefferson Health Plans.
- Jefferson Health Plans may pursue recovery from other responsible third parties after payment when permitted under applicable state and federal law.
- This exception applies only to services defined as preventive pediatric care under applicable Medicaid and EPSDT guidelines.

**Jefferson Health Plans CHIP – Enrollment and Other Insurance Restrictions:** Jefferson Health Plans CHIP is designed for children who are not eligible for Medical Assistance and generally may not have other creditable health insurance coverage.

If a CHIP member presents with other active health insurance, providers must:

- Verify eligibility with the other payer;
- Submit claims to the other payer first; and
- Notify Jefferson Health Plans for eligibility review.
- Jefferson Health Plans will determine whether CHIP coverage remains valid and will contact the member if coverage termination or changes are required.

Providers should report other insurance by calling the Provider Services Helpline at 1-888-991-9023 or by submitting the primary insurer's Explanation of Benefits (EOB).

## Authorization and Payment Requirements When Jefferson Health Plans Assumes Primary Responsibility

When a primary payer denies a claim, Jefferson Health Plans will evaluate whether it may assume primary payment responsibility in accordance with applicable law, contract, and program requirements.

### Assumption of Primary Responsibility

If a primary payer denies a claim for reasons not attributable to provider noncompliance with that payer's claim submission, authorization, or utilization management requirements, Jefferson Health Plans may assume primary payment responsibility when required by law, contract, or program rules and only when all of the following conditions are met:

- The service is covered under the applicable Jefferson Health Plans benefit plan; and
- All Jefferson Health Plans authorization, referral, billing, and utilization management requirements have been satisfied.

Failure to obtain required authorization or to comply with applicable Jefferson Health Plans requirements may result in claim denial.

### Provider Noncompliance with Primary Payer Requirements

Claims that could have been paid by a primary payer but were denied due to the provider's failure to comply with that payer's utilization management, authorization, or claim submission requirements will not be considered for payment by Jefferson Health Plans, unless payment is otherwise required by regulation, statute, or contract.

If payment is required despite a primary denial:

- Jefferson Health Plans' payment obligation may be limited to the amount that would have been payable had Jefferson Health Plans been the secondary payer, subject to applicable Jefferson Health Plans allowable amounts and contract terms.
- In no event may the member be billed for copayments, coinsurance, or deductibles that are prohibited under applicable program rules.

## Overpayments

Providers who participate with Jefferson Health Plans EverWell must participate in the Medical Assistance (MA) Program. Providers who participate in Medical Assistance enter into a written provider agreement with the State of Pennsylvania and must adhere to the MA Regulations. Under MA Regulation, (55 Pa. Code § 1101.69), a provider who is overpaid on a claim is obligated to reimburse the excess payment. This Regulation applies to money paid by the State or by us, as one of the state contracted MCOs. Providers who participate in Jefferson Health Plans CHIP must adhere to federal regulations relating to overpayments. Under Federal Regulations (42CFR489.21, 42CFR489.40 and 42CFR489.41), a provider who is overpaid is obligated to reimburse the excess payment.

There is no time limitation for requesting reimbursement of overpayments from providers receiving State or Federal Funds. Jefferson Health Plans EverWell and CHIP programs, however, follow the same recovery time period guidelines for non-fraud related claims as are adopted by DHS: two years from the date of payment notice. An exception exists if a requested reimbursement is based upon a State or Federally initiated audit such as a retrospective review in accordance with, but not limited to, 55 Pa. Code §§ 1101.51(e) and 1101.71(a), in which case the right to audit extends to ten (10) years from the expiration or termination of the Agreement or completion of the final audit, whichever is later.

In cases where we suspect a sustained or high level of payment error, we may initiate a medical records review based on a statistically valid random sample (SVRS) of claims, the results of which may be extrapolated to the larger claims universe for the purposes of determining an estimated overpayment or a claims reimbursement adjustment. We may employ industry-recognized software to identify providers with irregular billing patterns through a peer comparison analysis, as well as select the sample and estimate the overpayment.

Provider known overpayments with a check attached and provider overpayment form should be returned to:

> Jefferson Health Plans
> Attn: Finance-Cash Receipts
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107

If we discover an overpayment, recovery will be initiated and will be reflected on the provider's current Explanation of Payment. If the amount owed to us by a provider exceeds the amount of money to be paid within a payment cycle(s), an Explanation of Payment(s) will generate a $0 payment. The Provider is responsible for tracking their own balance until the credit balance is cleared.

### Provider Overpayment Form

Provider known overpayments must be returned along with a legible and completely filled out Provider Overpayment Form. When submitting a Provider Overpayment Form, please follow the submission guidelines provided at the top of the form.

The Provider Overpayment Form is available on the **Claim Overpayments** page of our website.

## Claim Overpayment Inquiries – No Returned Check

Please send claim overpayment inquiries that do not have a check through the **Provider Portal** with the provider overpayment form attached.

## Retroactive Disenrollments and Recovery

Jefferson Health Plans EverWell and Jefferson Health Plans CHIP members are occasionally retroactively disenrolled. When this occurs, any premiums paid to us are retracted by DHS or the Pennsylvania Insurance Department. Therefore, since we received no revenue to offset the member's medical expenses, we are under no obligation to pay for such services. When this happens, claim payments to providers will be retracted for services occurring within the retro-disenrollment period.

## Correct Coding Intervention

We apply correct coding standards that integrate nationally accepted guidelines including Current Procedural Terminology (CPT) logic as documented by the American Medical Association, and Correct Coding Initiatives (CCI) and post-operative guidelines as outlined by the Centers for Medicare & Medicaid Services to review claim submissions.

Codes determined to be included in or incidental to another procedure will be replaced with the more comprehensive code. Invalid codes that have been superseded with a current code may be replaced. If, however, there is any doubt about how to correct the coding, the claim will be denied for invalid coding, allowing the provider to take corrective action and re-file the claim. Pertinent modifiers must be used to communicate bilateral and repeated procedures performed on the same day.

Both the originally submitted code and the more accurate code will appear on the processed claim. The originally submitted code will have no payment.

The new code will have payment, if appropriate. An explanation of the coding modifications will be clearly documented on the Explanation of Payment.

## False Claims Act and Self-Auditing

Identifying and reporting Fraud, Waste and Abuse is everyone's responsibility. We take this very seriously and hold all employees, members, and providers accountable for reporting all concerns of Fraud, Waste and Abuse.

Providers in our network are responsible for auditing themselves and reporting any findings that would have resulted in an overpayment or underpayment to them. You can find self-auditing protocols on the U.S. Department of Health and Human Services (HHS) website at oig.hhs.gov/compliance/self-disclosure-info/protocol.asp, or on the Pennsylvania Department of Human Services (DHS) website at pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.

The Pennsylvania Medical Assistance (MA) Provider Self-Audit Protocol allows providers to report non-fraudulent overpayments and to return that money without DHS seeking damages.

The Office of Inspector General (OIG) Provider Self-Disclosure Protocol allows providers to self-disclose fraud, and that the OIG has implemented some benefits for providers to do so: Potentially receiving a lower multiplier on single damages which would normally be required in resolving a Government-initiated investigation.

Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages plus civil penalties ranging in amounts of approximately $13,000 - $27,000 per claim.

It is prohibited for any provider to solicit or receive or to offer or pay any remuneration, including any kickback, bribe, bonus or rebate, directly or indirectly, overtly or covertly, in cash or in kind from or to any person in connection with the furnishing of services or merchandise for which payment may be in whole or in part under the medical assistance program or in connection with referring an individual to a person for the furnishing or arranging for the furnishing of any services or merchandise for which payment may be made in whole or in part under the medical assistance program or a federal health care program.

### Hotline Information

If you wish to report Medicare, Medicaid, CHIP, or any other potential Fraud, Waste or Abuse, or other suspicious activity, please call our Special Investigations Unit (SIU) Hotline at (1-866-477-4848), the CMS Medicare Hotline Number at 1-800-MEDICARE (1-800-633-4227), or the Pennsylvania Department of Human Services Medicaid Hotline at 1-844-DHS-TIPS (1-866-379-8477).

Hotline calls can be made anonymously.

**Recipient Fraud:** Including, but not limited to, someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

**Provider Fraud:** Including, but not limited to, billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

## Claim Resubmissions

The procedures for claim resubmissions are provided in the section below.

- Professional claims must indicate corrected claim, and the original claim number must be provided.
- For all corrected claims, please use the frequency code 7.
- Claims must be submitted within 180 days of the EOP paid date of the original submission.

## Claim Inquiries and Reconsiderations

The procedures for inquiring about the status of claims or to request reconsideration of a payment decision are provided in the section below.

### Claim Inquiries

Providers may verify the following via the **Provider Portal**:

- claim status
- payment amount
- check date and number
- denial and denial reason

Providers can also use the telephonic option for all claim inquiries which are directed through us at 1-888-991-9023.

### Claim Reconsiderations

A provider can request a reconsideration determination for a claim that they believe was paid incorrectly or denied inappropriately, whether the result of a provider billing error or a Health Plan processing error. Providers should request the reconsideration of a claim using the **Provider Portal**.

All claims reconsideration requests must be received within 180 calendar days from the date of the Explanation of Payment (EOP) advising of the adjudication decision.

Claim reconsideration requests should include a copy of the EOP and documentation supporting the assertion that the claim was paid incorrectly or why the denial should be overturned. Other important points to remember:

- If the claim involves other insurance, provide information regarding the member's primary insurance coverage and include a copy of the primary EOP or Primary Insurance Denial Letter.

- If the claim was denied for lack of an authorization or services not matching the authorization, the provider must contact the appropriate utilization management area to address the authorization problem and, only when resolved, submit a claim reconsideration request. Denials such as these are not handled by the Claims Reconsideration department. The dispute with the authorization needs to be reviewed and handled by Utilization Management. Appeals for denied authorizations or lack of Inpatient authorizations should be mailed to Utilization Management:

Jefferson Health Plans
Attn: Inpatient Provider Appeals*
1101 Market Street, Suite 3000
Philadelphia, PA 19107

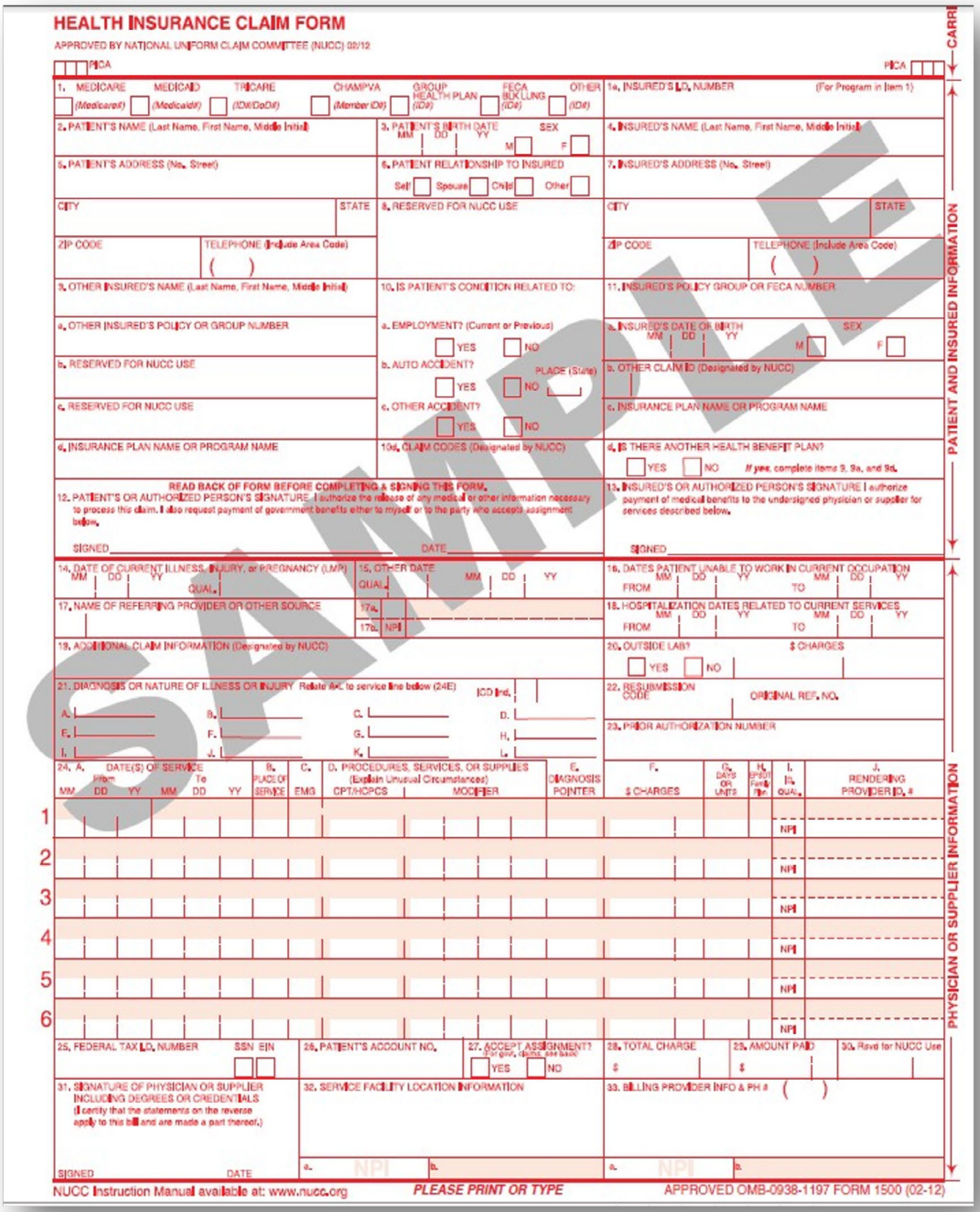
*Address to be used for inpatient authorization appeals only.

- If the claim was denied because the provider is non-participating and lacked authorization, and the provider believes he or she is participating, there may be a problem with credentialing. We must be contacted and this issue resolved before the claim can be reconsidered. Please contact us for assistance at 1-888-991-9023 to verify provider identification numbers.
- Claims denied because the requested authorization or level of care was not approved constitute a medical necessity disagreement.

The provider will be advised of the claim reconsideration outcome, generally within 30-45 calendar days of the date the written request was received by Claim Services via a response on the portal. For more information on the dispute and appeal process, please see **Chapter 13**, **Complaints, Grievances & Appeals**.

To request assistance with access to our provider portal, please follow the setup guidelines on our **Provider Portal** webpage.

# Sample CMS-1500 Form (Version 8-05 New Form)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRI

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

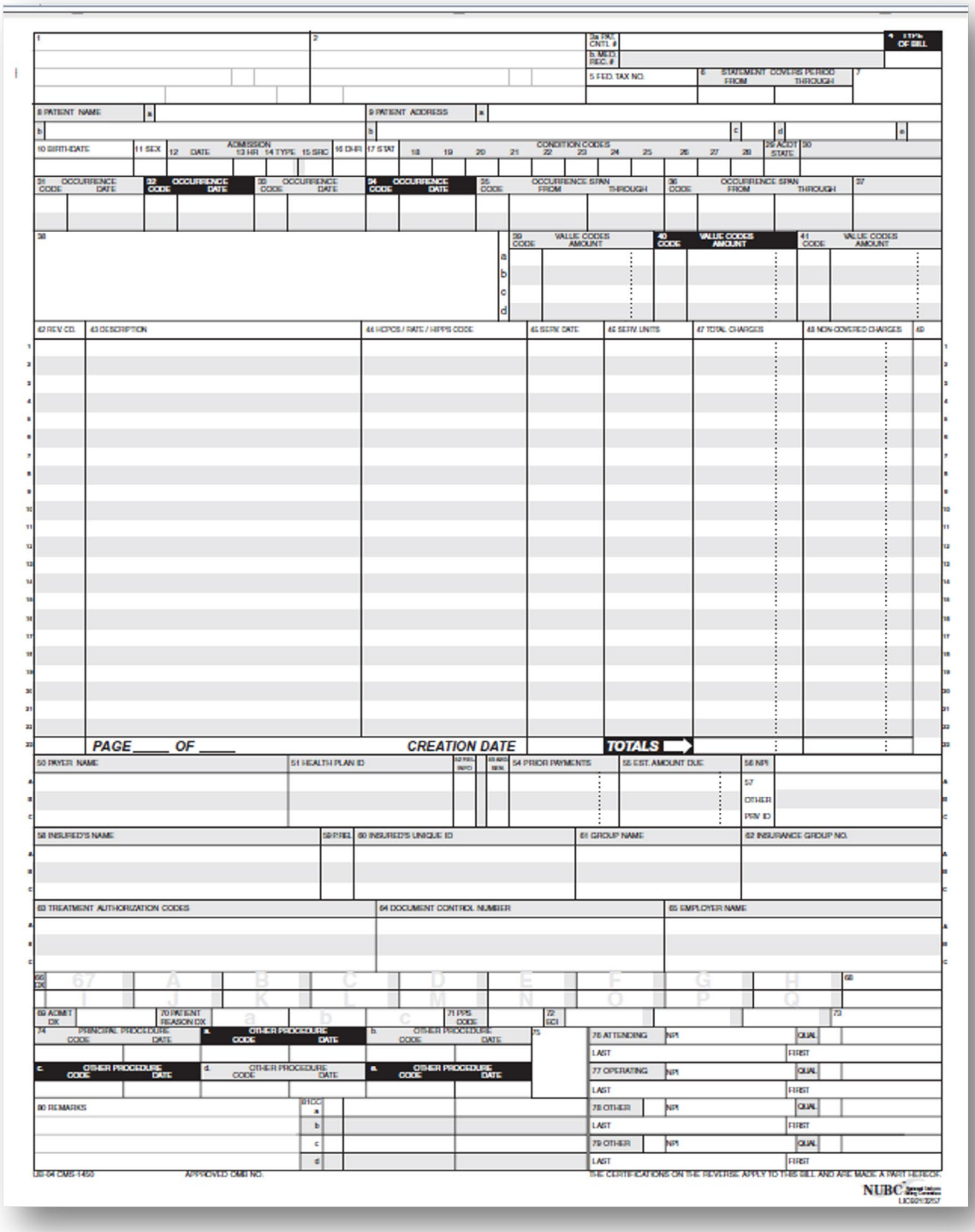
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

| Billing Requirements for CMS-1500 Form (Version 8-05 New Form) | | |
|---|---|---|
| **Field** | **Field Description** | **R (Required)<br>C (Conditional)<br>O (Optional)** |
| **1a** | Jefferson Health Plans ID number | R |
| **2** | Patient name (last name, first name, middle initial) | R |
| **3** | Patient's birth date and sex | R |
| **4** | N/A (Same as field #2) | R |
| **5** | Patient complete address and telephone number | R |
| **6** | Patient's relationship to insured | R |
| **7** | N/A (Same as field #5) | C |
| **8** | Patient's status | C |
| **9** | Other insured information | C |
| **10** | Is patient condition related to:<br><br>a. Employment?<br>b. Auto accident?<br>c. Other accident? | <br><br>R<br>R<br>R |
| **11** | Insured's policy group or FECA number | C |
| **11a** | Insured's date of birth | C |
| **11b** | Employer's name or school name | C |
| **11c** | Insurance plan or program name | C |
| **11d** | Is there another health benefit plan? | R |
| **12** | Patient's or authorized person's signature | R |
| **13** | Insured's or authorized person's signature | C |
| **14** | Date of current illness, injury, pregnancy | C |
| **15** | Date of same or similar illness | C |

| Billing Requirements for CMS-1500 Form (Version 8-05 New Form) | | |
|---|---|---|
| **Field** | **Field Description** | **R (Required)<br>C (Conditional)<br>O (Optional)** |
| **16** | Dates patient unable to work in current occupation | C |
| **17** | Name of referring physician | C |
| **17a** | Other referring ID number (must be reported with one of the NUCC qualifiers) | C |
| **17b** | NPI (the referring HIPAA NPI number) | C |
| **18** | Hospitalization dates related to current services | C |
| **19** | Medical License Number | R |
| **20** | Outside lab? | C |
| **21** | Diagnosis code(s) relate items to 24c by procedure line | R |
| **22** | Medicaid resubmission code (original DCN adjustments) | C |
| **23** | Prior authorization number | C |
| **24a** | Date(s) of service | R |
| **24b** | Place of service | R |
| **24c** | EMG | C |
| **24d** | Procedures, services, or supplies/modifiers | R |
| **24e** | Diagnosis pointer | R |
| **24f** | Charges | R |
| **24g** | Days or units | R |
| **24h** | EPSDT (family plan) | C |
| **24i** | Rendering provider other ID number (must be reported with one of the NUCC qualifiers) | C |
| **24j** | Rendering provider NPI ID number | C |

| Billing Requirements for CMS-1500 Form (Version 8-05 New Form) | | |
|---|---|---|
| **Field** | **Field Description** | **R (Required)<br>C (Conditional)<br>O (Optional)** |
| **25** | Federal tax ID number | R |
| **26** | Provider's patient account number | C |
| **27** | Accept assignment (assumed yes by Jefferson Health Plans contract) | C |
| **28** | Total charge | R |
| **29** | Amount paid | C |
| **30** | Balance due | C |
| **31** | Signature of physician or supplier | R |
| **32** | Service facility location information | C |
| **32a** | NPI number of the service facility location | C |
| **32b** | Other ID number (must be reported with one of the NUCC qualifiers) | C |
| **33** | Billing provider name, address, zip code, and phone number | R |
| **33a** | Billing/Group NPI | R |
| **33b** | Non-NPI—Other ID number (must be reported with one of the NUCC qualifiers) | O |

# UB-04 Claim Form



| Billing Requirements for UB-04 Claim Form<br>R (Required) \| C (Conditional) \| O (Optional) | | | |
|---|---|---|---|
| **Field** | **Field Description** | **Inpatient** | **Outpatient** |
| **1** | Provider name, address and telephone, county code | R | R |
| **2** | Pay-to name, address, pay-to ID | O | O |
| **3a** | Patient control number | R | R |
| **3b** | Medical record number | R | R |
| **4** | Type of bill | R | R |
| **5** | Federal tax number | R | R |
| **6** | Statement coverage period | R | R |
| **7** | Unlabeled | O | O |
| **8a** | Patient ID | O | O |
| **8b** | Patient name | R | R |
| **9** | Patient address and county code | R | R |
| **10** | Patient date of birth | R | R |
| **11** | Patient sex | R | R |
| **12** | Admission date of service | R | R |
| **13** | Admission hour | R | C |
| **14** | Type of admission/visit | R | C |
| **15** | Source of admission | R | R |
| **16** | Discharge hour | R | C |
| **17** | Patient discharge status | R | R |
| **18-28** | Condition codes | R | R |

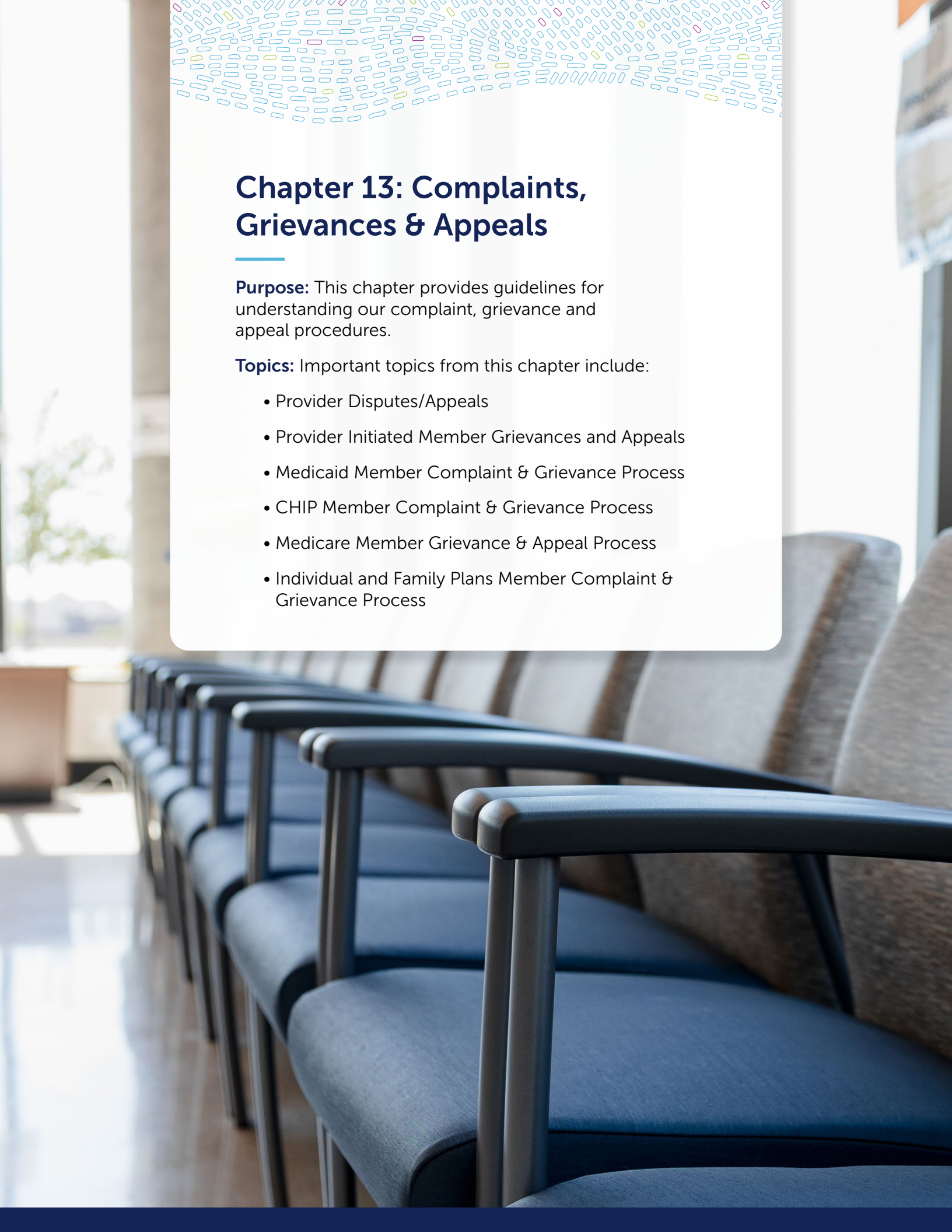
| Billing Requirements for UB-04 Claim Form<br>R (Required) \| C (Conditional) \| O (Optional) | | | |
|---|---|---|---|
| **Field** | **Field Description** | **Inpatient** | **Outpatient** |
| **29** | Accident state | C | C |
| **30** | Unlabeled | O | O |
| **31-34** | Occurrence code/date | C | C |
| **35-36** | Occurrence span code and dates | C | C |
| **37** | Unlabeled | O | O |
| **38** | Responsible party name/address | R | R |
| **39-41** | Value codes and amounts | C | C |
| **42** | Revenue code | R | R |
| **43** | Revenue description | R | R |
| **44** | CPT/HCPC Code, Modifier (if applicable) and Charge Amount | C | R |
| **45** | Service date | N/A | R |
| **46** | Units of service | R | R |
| **47** | Total charges by revenue code category | R | R |
| **48** | Non-covered charges | O | O |
| **49** | Unlabeled | O | O |
| **50a** | Payer name – primary | R | R |
| **50b** | Payer name – secondary | C | C |
| **50c** | Payer name – tertiary | C | C |
| **51** | Health Plan ID (Jefferson Health Plans Provider ID) | O | O |
| **52** | Release of information certification number | R | R |

| Billing Requirements for UB-04 Claim Form<br>R (Required) \| C (Conditional) \| O (Optional) | | | |
|---|---|---|---|
| **Field** | **Field Description** | **Inpatient** | **Outpatient** |
| **53a** | Assignment of benefits – primary | R | R |
| **53b** | Assignment of benefits – secondary | R | R |
| **53c** | Assignment of benefits – tertiary | R | R |
| **54** | Prior payment – payer and patient (a-c) | C | C |
| **55** | Estimated amount due | R | R |
| **56** | NPI billing provider (HIPAA provider number) | R | R |
| **57** | Non-NPI – Other ID number billing provider (must be reported with one of the NUCC qualifiers) | O | O |
| **58** | Insured's name | R | R |
| **59** | Patient's relationship | R | R |
| **60** | Insured's unique ID (HPP/Jefferson Health Plans ID number) | R | R |
| **61** | Insured's group name, if applicable | C | C |
| **62** | Insured's group number | C | C |
| **63** | Treatment authorization code | R | R |
| **64** | Document control number | C | C |
| **65** | Employer name | C | C |
| **66** | DX version qualifier (ICDv) | C | C |
| **67** | Principal diagnosis code | R | R |
| **67a-q** | Other diagnosis | C | C |
| **68** | Unlabeled | O | O |
| **69** | Admitting diagnosis code | R | N/A |

| Billing Requirements for UB-04 Claim Form<br>R (Required) \| C (Conditional) \| O (Optional) | | | |
|---|---|---|---|
| **Field** | **Field Description** | **Inpatient** | **Outpatient** |
| **70** | Patient's reason for visit code | C | C |
| **71** | PPS code - DRG code | R | C |
| **72** | External cause of injury code | C | C |
| **73** | Unlabeled | O | O |
| **74a-e** | Other procedure code/dates | C | C |
| **75** | Unlabeled | O | O |
| **76** | Attending NPI qualifier/ID number (first field NPI, second field qual + ID) | R | R |
| **77** | Operating physician NPI qualifier/ID number (first field NPI, second field qual + ID) | C | C |
| **78** | Other - qualifier/NPI qualifier/ID | C | C |
| **79** | Other - qualifier/NPI qualifier/ID | C | C |
| **80** | Remarks | O | O |
| **81** | Code-code-qualifier/code/value | C | C |

## Explanation of Payment (EOP)

This statement reports fee-for-service payments to providers, including PCPs, specialists, ancillaries and hospitals. (It does not report payments for capitated services.) The EOP reports claim charges that are paid or denied, and the reason for the payment or denial. The EOP also shows any coordination of benefits payments, any adjustments or interest payments, as well as the provider NPI and Health Plan legacy identification numbers. Additionally, the EOP indicates claims that have been modified to reflect correct coding as determined by Correct Coding Initiative and/or American Medical Association guidelines.



# Chapter 13: Complaints, Grievances & Appeals

**Purpose:** This chapter provides guidelines for understanding our complaint, grievance and appeal procedures.

**Topics:** Important topics from this chapter include:

- Provider Disputes/Appeals
- Provider Initiated Member Grievances and Appeals
- Medicaid Member Complaint & Grievance Process
- CHIP Member Complaint & Grievance Process
- Medicare Member Grievance & Appeal Process
- Individual and Family Plans Member Complaint & Grievance Process

# Overview



We provide several types of appeals to providers who are dissatisfied with our decisions. Depending on the nature of the issue, providers may be able to choose between more than one available appeal avenue. This chapter of the Provider Manual describes appeal options.

Appeal options include:

- Appeals of Inpatient Utilization Review
- Provider Quality of Care Sanctions and Appeals (see Chapter 9)
- Provider Dispute and Appeal Process (this process may not be used to appeal decisions that regard medical necessity, or provider sanctions.)
- Provider-Initiated Member Grievances (Act 68)

With the member's consent, a provider may appeal (grieve) a Health Plan decision on behalf of the member. A provider who pursues this appeal process may not additionally use the informal dispute resolution process described in Section V to appeal the same matter.

# Provider Dispute & Appeal Process (Medicaid Only)

This Provider Dispute & Appeal Process is available only for the Jefferson Health Plans EverWell plan and may not be used for any issues concerning medical necessity decisions, nor for provider sanctions (see Chapter 9, **Provider Quality of Care Sanctions and Appeals**). This process allows for informal and formal processes for settlement of Provider Disputes by providers in an equitable manner.

A Provider Dispute is a written communication to us from a Medicaid provider expressing dissatisfaction with a decision (other than a medical necessity decision or a provider sanction) that directly impacts the provider. The three matters that providers may bring through our Provider Dispute & Appeal process are:

- Provider credentialing denial by the plan
- Provider termination action by the plan, and
- Provider claim denials (for reasons other than medical necessity)

Providers are encouraged to follow the Claim Reconsideration process for quick resolution to billing and payment errors (see Chapter 12, **Claim Reconsiderations**). Providers may, however, access the Dispute & Appeal Process for initial claim denials. If a provider chooses to use the Dispute & Appeal Process for initial claim denials, the Dispute & Appeal Process filing deadlines apply, and the Claim Reconsideration process is no longer available as a resolution process. Further, any initial claim denials presented through the Claim Reconsideration process that result in continued provider dissatisfaction may be presented through the Dispute & Appeal Process. The Dispute & Appeal Process filing deadlines apply. The Provider Dispute & Appeal Process provides for the settlement of applicable issues as follows:

## Disputes

Providers have the right to file a dispute regarding provider credentialing denial, provider

termination, and claim denials (including denied payment for services already rendered). Providers have thirty (30) calendar days from the date of the written notice (credentialing denial, termination or claim denial) from us to file a dispute. All disputes must be in writing and mailed to:

> Jefferson Health Plans, Inc.
> Attn: Complaints, Grievances & Appeals Unit
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107

A provider representative (e.g., co-worker, friend, the provider's attorney, etc.) can assist the provider in filing a dispute. If a provider representative files a dispute on behalf of a provider, the provider must provide us with written authorization stating that said provider representative may act on the provider's behalf. The provider is given ten (10) calendar days to provide the proper authorization for said provider representation. The dispute process begins the date upon which the written authorization from the provider is received by our Complaints, Grievances & Appeals (CG&A) Unit.

## 1st Level Dispute Process (Informal)

The initial dispute is a 1st Level Dispute. After our Complaints, Grievances & Appeals Unit receives the request for the dispute process by the provider or the provider representative, we will initiate the 1st Level Dispute panel. The panel will consist of at least one person who has the authority, training and expertise to address and resolve provider dispute issues. The 1st Level Dispute panel has thirty (30) calendar days from the date of receipt of the 1st Level Dispute request to investigate and render a decision. The Complaints, Grievances & Appeals Unit has five (5) business days from the date of the 1st Level Dispute panel's resolution to forward the decision notification letter to the provider.

If the provider is dissatisfied with the decision, the provider may appeal the dispute to our 2nd Level Dispute (Internal Appeal) process.

## 2nd Level Dispute Process (Internal Appeal/Formal)

Following resolution of his/her 1st Level Dispute, a provider has the right to file a 2nd Level Dispute (Appeal). The 2nd Level Dispute (Appeal) by the provider is due within thirty (30) calendar days of the date of the 1st Level Dispute decision notification letter. All 2nd Level Disputes (Appeals) must be in writing and mailed to:

> Jefferson Health Plans, Inc.
> Attn: Complaints, Grievances & Appeals Unit
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107

The Complaints, Grievances & Appeals Unit will appoint a 2nd Level Dispute review committee that shall:

- include health care providers/peers not employed by us, comprising at least one-fourth (1/4) of the membership of the committee;
- include committee members who have the authority, training and expertise to address and resolve Provider Disputes (Appeals);
- have access to data necessary to assist committee members in making decisions; and
- document meetings and decisions of the committee.

Prior to the 2nd Level Dispute (Appeal) hearing, we will send a letter to the provider informing him/her of his/her right to appear before the 2nd Level Dispute (Appeal) panel. The provider's authorized representative (if applicable) also has the right to be present at the 2nd Level Dispute (Appeal) hearing. The provider must give the name of the provider representative to us at least two (2) business days prior to the 2nd Level Dispute (Appeal) hearing. Additionally, the same rules apply for appointing a provider representative as described above in this "Disputes" section.

The 2nd Level Dispute (Appeal) panel has thirty (30) calendar days from the date of receipt of the 2nd Level Dispute (Appeal) request to hold a hearing and render a decision. The CG&A Unit has five (5) business days from the date of the

2nd Level Dispute (Appeal) panel's resolution to forward the decision notification letter to the provider. The decision of the 2nd Level Dispute (Appeal) Committee is final and binding.

## Provider Dispute & Appeal Process for Suspensions/Terminations/Non-Renewal of Physician Contract (Medicaid & Medicare)

In-network providers that participate with both Medicaid and Medicare lines of business or Medicare Only and are suspended, terminated or denied re-credentialing have the following appeal rights:

### First Level Provider Appeal

- An appeal must be filed in writing by the provider or the provider's representative (with written permission of the provider) in order for the Complaints, Grievances and Appeals Unit to process the request as a written appeal. We will send the provider an acknowledgment letter within five (5) business days of receiving the Appeal.
- The provider will submit any material related to the appeal to us within ten (10) calendar days of the appeal.
- We have thirty (30) calendar days from the date the Appeal was received, to investigate, hold a Provider Appeal hearing and render a decision in the case.
- The majority of the Provider Appeal hearing panel members will consist of peers of the affected physician.
- We have five (5) business days after the Provider Appeal hearing panel makes the decision to forward a decision notification letter to the provider.
- If the decision is upheld, the provider has no further Medicare appeal rights, and the decision is final and binding.
- The provider can file a 2nd level appeal for the Medicaid line of business only. Please refer to the Medicaid 2nd Level Dispute Process (Internal Appeal/Formal) for further details.

### Sanctions and Appeals

In certain situations, a provider may be subject to review and sanctions by our Quality Management Committee. The provider has certain appeal rights concerning these Quality Management Committee decisions. For more information, see Chapter 9, **Provider Quality of Care Sanctions and Appeals**.

### Binding Arbitration Hearing

Applicable disputes will be referred to arbitration before a panel comprised of three (3) individuals. Both the provider and us will select one panel representative each, within 10 working days of receipt of the request for arbitration. The two panel representatives will then select a third panel representative to create the three-person arbitration board. If the two representatives cannot agree on the third representative within 14 days of the request for selection, the third panelist shall be drawn by lot from two candidates (one selected by the provider and one selected by us).

Upon selection of the third arbitrator, the arbitration board must issue its decision as expeditiously as possible in accordance with the procedures of the American Arbitration Association for handling such matters. Matters concerning level of care/placement decisions shall be reviewed and decided by the panel immediately. The arbitration proceeding will be conducted according to the prevailing rules of the American Arbitration Association. The decision of the arbitration board shall be binding and subject to review by DOH.

The entire cost of the arbitration proceeding shall be borne by the losing party.

*Note: We will not exclude a provider from its provider network because the provider advocated on behalf of a member in a utilization management appeal or another dispute with us over appropriate medical care. Additionally, we cannot terminate a contract or employment with a health care provider for filing a grievance on a member's behalf.*

## Provider-Initiated Member Grievances (Medicaid and CHIP Only)

This information pertains to Jefferson Health Plans EverWell and Jefferson Health Plans CHIP members. With the written permission of the member, providers have the right to appeal on behalf of the member. While a provider may request the member's written consent prior to treatment, he or she may not (as a condition of treatment) require that the member sign a document authorizing the provider to file a grievance.

Applicable regulations provide specific requirements and time frames that must be adhered to. When the member gives the provider permission to file a grievance or appeal, the provider must assure timely compliance with the requirements, since he or she has assumed the member's grievance and appeal rights. The member, however, may rescind consent at any time.

When the provider initiates a member grievance or appeal, he or she may not bill the member for the services that are the subject of the grievance until an external grievance review has been completed, or unless the member has rescinded the consent. Jefferson Health Plans EverWell members may never be billed or balance billed for covered services.

In situations where the provider is prohibited from billing the member, or if the provider chooses to never bill the member for the services being grieved, he or she may drop the grievance. The provider must notify the member or the member's legal representative in order to do so.

A member may ask another person to serve as his/her representative in the appeal process. This person is then termed the "member's representative." If the representative is a health care provider, the provider must have the member's written consent to file/pursue a grievance or appeal. Documentation of member consent must be submitted with the request. A provider may obtain the member's written permission at the time of treatment. However, the provider must not require a member to sign a document authorizing the provider to file an appeal as a condition of treatment. Either the member or the member's legal representative may provide this consent.

The written consent giving a provider authority to file/pursue a grievance or appeal as the member's representative must contain each of the following:

- The member's name, address, date of birth, and plan identification number.
- When the member is a minor or legally incompetent: the name, address and relationship to the member of the person signing the consent on behalf of the member.
- The name, address and identification number of the health care provider who is obtaining consent from the member.
- The name and address of the plan that will receive the grievance or appeal.
- A description of the specific service(s) (whether coverage was provided or denied) that the consent will apply to.
- The signature and date of signature of the member, or (if a minor or legally incompetent) the member's legal representative; and
- the signature and date of signature of a witness.

The written consent must also include the following statements:

- The member or member's legal representative may not file a grievance or appeal about the service(s) listed in the consent form unless the member or member's legal representative rescinds the consent in writing. The member or member's legal representative has the right to rescind this consent at any time during the grievance or appeal process.

- If the provider fails to file the grievance or appeal or does not continue to pursue the grievance or appeal through the second-level review process, the consent of the member or member's legal representative will be rescinded automatically.
- The member (or the member's legal representative, if the member is a minor or legally incompetent) has read (or has been read) this consent document and has had it explained to his/her satisfaction. The member or member's legal representative understands the information in the member's consent form.

A member may rescind his/her consent at any time throughout the grievance and appeal process. If the member rescinds consent, he/she may continue the grievance from the point at which consent was rescinded. A member may not file a separate grievance or appeal on the same matter. If a member files a grievance or appeal, he/she may, at any time during the grievance or appeal process, choose to give consent to a health care provider to continue the grievance or appeal on behalf of the member. A member's legal representative may similarly exercise these member rights.

Please note that, if a provider uses the following process, he or she may not also use the informal dispute resolution process described under Appeals of Inpatient Utilization Review Decisions to appeal the same matter.

Under Pennsylvania Code Title 28, chapter 9-9.706 (c) (g), (c), once a health care provider assumes responsibility for filing a grievance, the health care provider may not bill the enrollee or the enrollee's legal representative for services provided that are the subject of the grievance until the external grievance review has been completed or the enrollee or the enrollee's legal representative rescinds consent for the health care provider to pursue the grievance. If the health care provider chooses never to bill the enrollee or the enrollee's legal representative for the services provided that are the subject of the grievance, the health care provider may drop the grievance with notice to the enrollee and the enrollee's legal representative in accordance with subsection (g).

Subsection (g) reads as follows:

(g) The provider, having obtained consent from the enrollee or the enrollee's legal representative to file a grievance, shall have 10 days from receipt of the standard written UR denial and any decision letter from a first, second or external review upholding the plan's decision to notify the enrollee or the enrollee's legal representative of its intention not to pursue a grievance.

## Grievances (Medicaid and CHIP only)

When we deny, decrease, or approve a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, or health care provider or other member's representative (with the appropriate written consent of the member) to request that we reconsider our decision. Specifically, a decision may be grieved that:

- Denies or provides limited authorization for a requested service, including its type or level.
- Reduces, suspends or terminates a service that was previously authorized.
- Denies the requested service and approves an alternative.
- Denies payment, fully or in part, for a service, based on lack of medical necessity.

## Provider-Initiated Member Grievances

The member, or member's representative, or provider (with member's written consent) must file the grievance within 60 days from the date of receipt of notification about the decision. In order to initiate a grievance on behalf of a member, the provider must submit the member's written consent with the request for a grievance. This member consent may be obtained at the time of treatment. However, the provider must not require a member to sign a document authorizing the provider to file a grievance as a condition of treatment.

A provider appealing with consent of the member should send the written grievance to:

> Jefferson Health Plans
> Attn: Complaints, Grievances & Appeals Unit
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107

When a grievance is received, we issue a written confirmation to the member, the member's representative (if designated), and the provider (if the provider has filed the grievance with member consent). The letter will provide additional information about the grievance review process, including:

- Classification of the matter as a grievance versus a complaint. The member, member's representative, or provider may question this classification by contacting the Pennsylvania Department of Health.
- ht of the member to appoint a representative to act on his/her behalf at any time during the internal grievance process.
- The ability of the member, member's representative, or provider that filed the grievance (with member consent) to review information related to the grievance upon request. They may also submit additional information to us for consideration.
- The right of the member or member's representative to request that a Jefferson Health Plans staff member (who has not participated in the utilization management decision) help prepare the first-level grievance, at no charge.
- Notice that the member, member's representative, and provider will be given 10 days written, advance notice of the scheduled review, and that they have the right to attend and participate.

We will consider the member's access to transportation, as well as any disabilities or language barriers, and will make reasonable accommodation to permit the member, member's representative, and the provider to participate, in person, by conference call, or by video conference. When the member, member's representative, or the provider cannot attend the review in person, we will provide the opportunity to communicate with the committee by other appropriate means, such as telephone and video conference.

A committee made up of three (3) or more individuals whose members have not been involved in any prior decision and are not the subordinates of an individual involved in any prior decision regarding the grievance will provide the grievance review. A licensed physician or an approved licensed psychologist (practicing in the same or similar specialty that would typically consult on the health care services in question) will be a committee member. Other appropriate providers may participate in the review, but the licensed physician must decide the grievance. At least one third of the grievance review committee may not be employees of ours or a related subsidiary or affiliate.

We will provide the member, member's representative, or provider that filed a grievance (with member consent) access to all information about the matter being decided. We will allow for written information or other additional material to be introduced in support of the grievance. The member, member's representative, or provider may directly voice the remedy or corrective action which they are asking of us.

Grievance review attendance is limited to these people:

- Review committee members who are not employees of ours
- Appropriate plan representatives
- The member or the member's representative(s), including legal representation and/or any attendant necessary for the member's participation in and understanding of the proceedings
- The provider who grieved the matter with the member's consent
- Any pertinent witnesses

All persons attending this meeting will need to identify themselves and their role in the grievance process for the member and any representatives for the member that are present. The committee will base the review decision on the materials and testimony presented during the review meeting only. Committee members may not discuss the case prior to the review meeting. Committee members must attend the review meeting in person or participate actively by telephone or video conference (and have an opportunity to review any information introduced at the review meeting prior to voting), or they may not vote. An attorney may represent the committee's interests at the review meeting but may not argue the plan's position or represent its staff. A summary of the meeting's proceedings will be produced from an electronic recording. This summary will become part of the grievance record and will be included in the information the plan sends if there is a request for an external grievance review.

We will reach a decision and notify the member, member's representative, and provider within 30 days from receiving a grievance. A 14-day extension may be requested by the member, member's representative, or the provider who filed the grievance with written consent of the member. This notice will include the basis for the decision, and will explain how to request a Fair Hearing from the Department of Human Services (DHS) (ONLY applicable for Medicaid members, Fair Hearings are NOT available in the CHIP program), an external review of the decision by the Pennsylvania Insurance Department (PID) for Medicaid members, or an external review of the decision by the Pennsylvania Department of Health for CHIP members, or both a request for a Fair Hearing and a request for an external review of the decision for Medicaid members.

The notice will specifically include:

- A statement of the matter reviewed by the committee.
- The specific reasons for the committee's decision.
- Corresponding provisions that were the basis for the decision, and how to obtain copies of any documents used.
- The scientific or clinical judgment behind the decision.

Information on how to file a Fair Hearing from the Department of Human Services (DHS), an external review of the decision by the Department of Health (DOH), or both a request for a Fair Hearing and a request for an external review of the decision.

Medicaid members may ask for an external review of the decision by the Pennsylvania Insurance Department (PID) within fifteen (15) days from receipt of the decision. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of decision.

CHIP members may ask for an external review of the decision by the Pennsylvania Department of Health (DOH) within fifteen (15) days from receipt of the decision.

## Expedited Grievances

If the member's life, health or ability to regain maximum function would be jeopardized by delay caused by the standard review process, an Expedited Grievance may be filed. The member, member's representative, or provider (with written consent of the member) may file this request by calling us.

To obtain an expedited review, we must be provided with written certification from the member's physician that the member's life, health, or ability to regain maximum function would be jeopardized by delay. This certification must include the physician's clinical rationale and facts that support his/her opinion. The certification must include the provider's signature. If the provider certification is not included with the request for an expedited review, we must inform the member that the provider must submit a certification as to reasons why the expedited review is needed and why the grievance cannot be processed within the standard thirty (30) day time frame.

The expedited grievance will be put into writing. A committee of three or more people, including a licensed doctor and a Health Plan member, will review the grievance. The licensed doctor will decide the expedited grievance with help from the other representation on the committee. No one on the committee will have prior involvement with the grievance. The expedited grievance process will follow the process described above under Provider-Initiated Member Grievances (Act 68 Process), with these exceptions:

- A 48-hour time frame of receiving the provider certification or seventy-two (72) hour timeframe of receiving the Member's request for an expedited review applies, whichever is shorter.
- If the member cannot attend the hearing in person due to the short time frame, the hearing may be held by telephone or video conference. In this case, all information presented will be read into the record.
- If the member cannot be provided with a copy of the report of the same or similar specialist prior to the expedited hearing, we may read the report into the record at the hearing and provide a copy of the report to the member at that time.
- To allow us to conform to the time requirements of this section, it is the responsibility of the member, member's representative, or provider to provide information to the plan in an expedited manner.

We will conduct an expedited internal review and issue a decision within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. The decision notice to the member, member's representative or provider will state the basis for the decision and include any clinical rationale. It will also give the procedure for requesting an expedited external review and, if applicable, a DHS Fair Hearing. (Fair Hearings are not available in the CHIP program.) The member, member's representative or provider (with written consent of the member) has two business days from receipt of the expedited grievance decision to request an expedited external review. The member may file a request for a DHS Fair Hearing within one hundred twenty (120) days from the mail date on the written notice of our expedited Grievance decision.

If an expedited external review is requested, we will submit a request to the Pennsylvania Insurance Department (PID) for Medicaid members or Pennsylvania Department of Health (DOH) for CHIP members by fax and telephone within 24 hours of receiving a request from the member, member's representative or provider with member's written consent. The Pennsylvania Insurance Department (PID) or Pennsylvania Department of Health (DOH) will assign a certified review entity (CRE) to the case within one business day of receiving the expedited review request. The CRE will make a decision within two business days following its receipt of the case file.

# Medicaid Member Complaints, Grievances, and Fair Hearings Process

## Jefferson Health Plans EverWell Member Complaint & Grievance Process

Information pertaining to Jefferson Health Plans EverWell Member Complaint, Grievance and Fair Hearing process can be found at:

JeffersonHealthPlans.com/Medicaid/For-Members/Member-Resources/

Change this to Jefferson Health Plans EverWell (Medicaid) members **ONLY**.

## Jefferson Health Plans CHIP Member Complaint & Grievance Process

Information pertaining to Jefferson Health Plans CHIP Member Complaint and Grievance process can be found at:

JeffersonHealthPlans.com/CHIP/For-Members/Member-Resources/

This information pertains to Jefferson Health Plans CHIP members **ONLY**

# Jefferson Health Plans Medicare Advantage Member Grievance & Appeal Process

This information pertains to Jefferson Health Plans Medicare Advantage members **ONLY**.

## Grievances

A Grievance means any complaint or dispute other than the one involving an organization determination, expressing dissatisfaction with any aspect of Jefferson Health Plans Medicare Advantage providers' operations, activities, or behavior, regardless of whether remedial action is requested.

Members have (60) calendar days from the date of the incident or the date the member receives written notice of a decision to file a grievance. Grievance requests must be filed orally or in writing with Jefferson Health Plans Medicare Advantage. A grievance can be filed on behalf of a member by a provider or other representative. The member's written authorization must be included with the grievance request.

For quality of care issues, a member may file a grievance with Jefferson Health Plans Medicare Advantage or file a written complaint with CMS's contracted Quality Improvement Organization (QIO). If a quality of care complaint is filed with QIO, Jefferson Health Plans Medicare Advantage will work with the QIO to resolve the complaint.

### Standard Grievance

Jefferson Health Plans Medicare Advantage will respond to a member's grievance within (30) calendar days. We may extend the 30-day review period by up to 14 days if requested by the member, or if we justify the need for additional information. If Jefferson Health Plans Medicare Advantage extends the 30-day review period, the member and the representative involved will be notified in writing of the reason for delay. A grievance decision notice will be issued no later than the expiration of the extension.

### Expedited Grievance

Jefferson Health Plans Medicare Advantage must respond to a member's grievance within 24 hours in the following instances:

- The grievance involves Jefferson Health Plans Medicare Advantage's decision to invoke an extension to the time frame required for an organization determination in response to a service request or reconsideration (appeal).
- The grievance involves Jefferson Health Plans Medicare Advantage's refusal to grant the member's request for an expedited organization determination in response to a service request or expedited reconsideration (appeal).

## Reconsideration (Appeal) Process

Providers must adhere to the Medicare appeals and expedited appeals procedures, including gathering/forwarding information on appeals as necessary and as described in the Code of Federal Regulations (42 CFR 422 Subpart M).

### Reconsideration (Appeal) Request

A reconsideration consists of a review of an adverse Jefferson Health Plans Medicare Advantage's determination notice. If the request is not filed in 60 calendar days, the member (or the members' authorized representative) may request that the reconsideration time frame be extended. The request for the reconsideration and extension of the time frame must be written and must state why the request was not filed in a timely manner.

In order for Jefferson Health Plans to process a standard reconsideration (appeal) request for service or payment from a contracted plan provider on behalf of a member, Jefferson Health Plans must obtain an Appointment of Representation from the member, authorizing the medical provider to represent the member during the appeal process.

*Note: Non-contracted providers may appeal on behalf of a member by obtaining an Appointment of Representation form. When acting as a representative of the member, a non-contracted provider is prohibited from participating as an independent party (appellant) to the appeal.*

### Standard Reconsideration (Appeal) of Service Determination

Jefferson Health Plans Medicare Advantage will issue a written determination for a service reconsideration request as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date we received the request for a standard reconsideration.

We may extend the 30-day time frame by 14 days. If Jefferson Health Plans Medicare Advantage extends the time frame, we will notify the member in writing of the reasons for delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

When Jefferson Health Plans Medicare Advantage makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case file to MAXIMUS as expeditiously as the member's health condition requires but no later than 30 days from receipt of the reconsideration request, subject to an additional 14-day extension.

> MAXIMUS Federal Services/Part C
> Medicare Managed Care
> Reconsideration Project
> 3750 Monroe Ave. Suite 702
> Pittsford, New York 14534-1302
> Phone: 1-585-348-3300

### Standard Reconsideration (Appeal) of Payment Determination

Jefferson Health Plans Medicare Advantage will issue a written determination for payment reconsideration requests no later than 60 days from the date we received the request for a standard reconsideration.

When Jefferson Health Plans Medicare Advantage makes a reconsideration determination that upholds the initial denial, in whole or in part, we will prepare a written explanation and send the case/file to MAXIMUS within 60 days of receipt of the reconsideration request.

## Expediting Certain Reconsiderations

A member or a physician (contracted or not contracted) may request that Jefferson Health Plans Medicare Advantage expedite a reconsideration of a determination that involves our refusal to provide or pay for services that the member believes should be furnished or arranged for if the member believes that the continuation of services is medically necessary.

The expedited reconsideration (appeal) time frames will be applied in the following circumstances:

- A member requests reconsideration (appeal) because he/she missed the deadline to request QIO review of a non-coverage of an inpatient hospital care decision following his/her receipt of Notice of Medicare Non-Coverage (NOMNC).

- A member requests reconsideration (appeal) because he/she missed the deadline to file a Fast Track appeal request with the QIO following his/her receipt of a 2-day advance termination notice from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) provider.
- Contracted and non-contracted physicians may initiate an expedited reconsideration without appointment of representation or Waiver of Liability documents.

## Plan's Refusal to Expedite a Reconsideration Request

If Jefferson Health Plans Medicare Advantage denies a member's request for expedited reconsideration, we will give the member prompt oral notice and subsequently deliver, within 3 days, a notice to the member explaining that the request will automatically be transferred to the 30-day time frame for standard reconsiderations. The notice will also inform the member of the right to file a grievance if he/she disagrees with the decision not to expedite as well as the member's right to resubmit a request for an expedited reconsideration with any physician's support.

## Plan's Decision to Expedite a Reconsideration Request

Those requests made or supported by a physician will be accepted as expedited if the physician indicates that applying the standard 30-day time frame for conducting reconsideration could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Jefferson Health Plans Medicare Advantage will complete the reconsideration and give the member (and physician involved, as appropriate), notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. We may extend the 72-hour deadline by up to 14 days. If Jefferson Health Plans Medicare Advantage extends the time frame, we will notify the member in writing of the reason for the delay and inform the member of his/her grievance rights if the member disagrees with our decision to extend the time frame.

If Jefferson Health Plans Medicare Advantage first notifies the member (and physician involved as appropriate) orally of a completely favorable expedited reconsideration, we will issue a written confirmation within 3 days. If our expedited reconsideration determination upholds the initial determination (denial), in whole or in part, we will submit a written explanation and the case file will go to MAXIMUS as expeditiously as the member's health condition requires, but no later than 24 hours from our determination. Jefferson Health Plans Medicare Advantage will concurrently notify the member (and the physician involved, as appropriate) that the case file has been submitted to MAXIMUS.

## Medicare Part D Grievance and Redetermination (Appeal) Process

### Appeal Process

Appeals must be requested within 65 calendar days after the date of determination. Jefferson Health Plans Medicare Advantage can give the member more time if there is a good reason for missing the deadline. Members/providers have the right to ask Jefferson Health Plans Medicare Advantage for an exception if they believe a drug that is not on the formulary should be covered or if the drug should be covered at a lower cost sharing amount. They can also ask for an exception to utilization management tools, such as a dose restriction or step therapy requirement. The physician must provide a statement to support the exception request.

### Requesting an Appeal

Members, their prescribing physician, or their appointed representative may request an appeal. A relative, friend, advocate, attorney, doctor, or someone else can act for the member. Others may already be authorized under State law to act on behalf of the member.

Jefferson Health Plans Medicare Advantage can be reached at:

1-800-901-8000,
October 1 – March 31: seven days a week, from 8 a.m. to 8 p.m., April 1 – September 30: Monday through Friday, from 8 a.m. to 8 p.m.

If members have a hearing or speech impairment, please call us at TTY 1-877-454-8477.

## Problem Resolution – Part D

The following is communicated to all Jefferson Health Plans Medicare Advantage members.

There are two kinds of appeals you can request:

**Expedited (72 Hours)** – You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- If the doctor who prescribes the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates waiting for 7 days could seriously harm your health, we will automatically expedite the appeal.
- If you ask for an appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

**Standard 7 Days** – You can request a standard appeal. We must give you a decision no later than 7 days after we get your request.

### What do I include with my appeal request?

You should include your name, address, Member ID number, the reason for your appeal, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would either harm your health or not be as effective to treat your condition as the requested off-formulary drug.

### How do I request an appeal?

**For an Expedited Appeal:** You or your appointed representative should contact us by telephone or fax us at:

Phone: 1-866-901-8000
(TTY 1-877-454-8477)
Fax: 215-991-4105

**For a Standard Appeal:** You or your appointed representative should mail or deliver your written appeal request to:

Jefferson Health Plans
Attn: Complaints, Grievances & Appeals Department
1101 Market Street, Suite 3000
Philadelphia, PA 19107

### What Happens Next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with the decision, you will be notified of your appeal rights.

### Contact Information:

If you need information or help, call us at: 1-866-901-8000 (TTY 1-877-454-8477).
Other Resources to help you:

**Medicare Rights**
Toll Free: 1-888-HMO-9050

**Center Elder Care Locater**
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TYY: 1-877-486-2048

# Individual and Family Plans Member Grievance & Appeal Process

This information pertains to Jefferson Health Plans Individual and Family plans members **ONLY**. Our Members are given this information about the Individual and Family Plans grievance and appeal process:

**Grievance** – A complaint by a member or member's authorized representative concerning any aspect of the operations, activities, or behavior of the health plan, or its providers, regardless of whether remedial action is requested.

Here are a few instances in which You would submit a Grievance:

- Quality of Your medical care
- Respecting Your privacy
- Waiting times
- Customer Service of Jefferson Health Plans' staff or Provider staff
- Cleanliness of a Provider's office
- Dissatisfaction with contractual benefits
- Timeliness of Our actions related to coverage decisions and appeals

**Adverse Benefit Determination** – An Adverse Benefit Determination may be any of the following:

- A decision by the Plan or someone on behalf of Plan to deny a service or payment for a service. This decision is based on a review of the information provided and the request does not meet [Insurer's] requirements for:
- medical necessity
- appropriateness
- the type of health care setting
- the level of care
- effectiveness of the service
- The service is considered to be experimental or investigational.
- The service is not covered by this policy.
- A cancellation of coverage determination by Jefferson Health Plans.

**Final Adverse Benefit Determination** – Happens when Jefferson Health Plans' decision to deny an initial request is partially or fully upheld by Jefferson Health Plans' internal appeal process.

**Internal Appeal** – An Internal Appeal is a request by a member, a member's authorized representative, or a health care provider, with the written consent of the Member, to have the Plan reconsider a decision concerning an Adverse Benefit Determination, or the Plan's compliance with the surprise billing and cost-sharing protections under the No Surprises Act.

**External Review** – An External Review is a review by an Independent Review Organization of the Plan's decision to deny coverage for or payment of a service. You can request an External Review by contacting the Pennsylvania Insurance Department.

## If a Member Wants to File a Grievance

Call Jefferson Health Plans' Member Services at:

- 1-833-422-4690 (TTY: 1-877-454-8477) and tell Jefferson Health Plans your Grievance, or
- Write down your Grievance and send it to Jefferson Health Plans by mail or fax, to:

> Jefferson Health Plans
> Member Appeals Department/CGA Unit
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107
> 215-991-4105 (fax)

You can also have someone else request a Grievance for you if you give that person your consent in writing to do so.

You can submit a Grievance to Jefferson Health Plans if it has been one year or less from the incident or action leading to the dissatisfaction. We will acknowledge receipt of your Grievance within 5 business days of receipt of your request. Your Grievance will be reviewed by a 1st Level Grievance Review Committee consisting of one Plan employee who had no previous involvement with your case. If your Grievance is concerning a clinical issue, a Plan Medical Director will make the decision on your Grievance. Jefferson Health Plans will send you a decision concerning your Grievance within 30 calendar days of receipt of your Grievance. The letter will also include information regarding how to file a 2nd Level Grievance with Jefferson Health Plans if you do not agree with our decision.

## 2nd Level Grievance

If you are not happy with the outcome of your 1st Level Grievance, you can request a 2nd Level Grievance from Jefferson Health Plans. You have 60 days from receipt of the 1st Level Grievance decision letter to request a 2nd Level Grievance. We will acknowledge receipt of your 2nd Level Grievance within 5 business days of receipt of your request. Your 2nd Level Grievance will be reviewed by a 2nd Level Grievance Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the 1st Level Grievance decision. The 2nd Level Grievance Committee members will include Jefferson Health Plans' staff, with one third of the committee being Members or other persons who are not employed by Jefferson Health Plans. If your Grievance is concerning a clinical issue, a Plan Medical Director will serve on the committee. You have the right to present your Grievance appeal to the committee. You may submit supporting materials both before and at the 2nd Level Grievance Review. Jefferson Health Plans will send you a decision concerning your 2nd Level Grievance within 45 calendar days of receipt of your 2nd Level Grievance request. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department as described in the decision letter.

## If You Want to File an Internal Appeal

Call Jefferson Health Plans' Member Services at:

- 1-833-422-4690 (TTY: 1-877-454-8477) and tell Jefferson Health Plans that you want to request an Appeal, or
- Write down your Appeal request and send it to Jefferson Health Plans by mail or fax, or
- If you received a notice from Jefferson Health Plans telling you Jefferson Health Plans' decision and the notice included an Internal Appeal Request Form, fill out the form and send it to Jefferson Health Plans by mail or fax.

> Jefferson Health Plans
> Member Appeals Department/CGA Unit
> 1101 Market Street, Suite 3000
> Philadelphia, PA 19107
> 215-991-4105 (fax)

Your provider can file an Internal Appeal for you if you give the provider your consent in writing to do so.

You can submit an Internal Appeal to Jefferson Health Plans if it has been 180 calendar days or less from your receipt of the denial letter from Jefferson Health Plans. We will acknowledge receipt of your Internal Appeal within 5 business days of receipt of your request. If you are currently receiving services, we are required to provide continued coverage pending the outcome of the Appeal. To continue receiving services, you must file your request for an Internal Appeal within 10 days of the date on the denial letter. Your Appeal will be reviewed by an Internal Appeal Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Internal Appeal Review Committee members will include Jefferson Health Plans' staff, including a Plan medical director who is a matched specialist or a consultant who is a matched specialist who holds an active unrestricted license to practice medicine. A matched specialist or "same or similar specialty Physician" is a licensed Physician, Dentist or Psychologist who: is in the same or similar specialty as typically manages the

care under review. One third of the Committee will be Members or other persons who are not employed by Jefferson Health Plans. You will have an opportunity to submit supporting materials and testimony for your Appeal. In addition, if Jefferson Health Plans receives new or additional information after the initial adverse determination, we will provide this information to you for your review prior to the Committee Review. Jefferson Health Plans will send you a decision concerning your Internal Appeal within 30 calendar days of receipt of your Internal Appeal request. The letter will also include information regarding how to file an External Review with an Independent Review Organization if you do not agree with our decision.

If Jefferson Health Plans fails to issue a written decision concerning your Internal Appeal within 30 days following the date the Plan receives your request, and you or your authorized representative have not requested or agreed to an extension on your Internal Appeal, you may proceed to an external review.

## Expedited Internal Appeal

If you or your doctor believes that your life, health, or ability to regain maximum function would be placed in jeopardy by waiting 30 days to get your decision on your Internal Appeal, you or your doctor can request an Expedited Internal Appeal. You may also request an Expedited External Review with an Independent Review Organization at the same time that you request an Expedited Internal Appeal. Upon receipt of your request, we will promptly inform you whether your request qualifies for expedited review or instead will be processed as a standard Internal Appeal. Your Expedited Internal Appeal will be reviewed by an Expedited Internal Appeal Review Committee consisting of 3 or more persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Expedited Internal Appeal Review Committee members will include Jefferson Health Plans' staff, including a Plan medical director who is a matched specialist or a consultant who is a matched specialist, and one third of the committee being Members or other persons who are not employed by Jefferson Health Plans. You will have an opportunity to submit supporting materials and testimony for your Appeal. You may submit supporting materials both before and at the Expedited Internal Appeal Review Committee. Jefferson Health Plans will notify you of its decision concerning your Expedited Internal Appeal both orally and in writing within 48 hours of receipt of your Expedited Internal Appeal request. If you are not satisfied with outcome of your Expedited Internal Appeal you can request an Expedited External Review with an Independent Review Organization as outlined below.

## External Review

If your request for a service was denied, you may have the right to file a request for independent external review of an Adverse Benefit Determination or a Final Adverse Benefit Determination. This independent external review would be done at no cost to you.

### What other rights do I have?

You also have the right to a review of whether we have complied with the surprise billing and cost-sharing protections under the No Surprises Act.

For example, if you receive a covered health care service at an in-network facility, you may not be charged a bill for other than your in-network cost-sharing.

For more information on this, you can visit the Pennsylvania Insurance Department's website dedicated to this topic:

insurance.pa.gov/nosurprises.

### How do I ask for an independent external review?

For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at:

insurance.pa.gov/externalreview.

To submit a request for either standard or expedited independent external review, you must submit a copy of your adverse benefit determination or final adverse benefit determination notice and a completed independent external review request form to:

**Mail:** Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

**Fax:** 717-231-7960

**Email**: ra-in-externalreview@pa.gov

**Phone:** Consumer Services
1-877-881-6388

### What happens next?

Once the Insurance Department receives your request, your eligibility for independent external review will be confirmed with us.

If your adverse benefit determination or final adverse benefit determination is eligible for independent external review, the Insurance Department will assign an Independent Review Organization and provide you with notice of the assignment and information on how you may submit information to support your position. The Independent Review Organization will issue a decision to uphold, partially uphold, or overturn our decision based on the information provided by you and by us.

### Contact Information

If you need information or help, call us at: 1-833-422-4690 (TTY: 1-877-454-8477).
Other Resources to help you:

To ask for free legal help with your Grievance or Appeal, you can call:

**Pennsylvania Health Law Project**
1-800-274-3258 (phlp.org)

**Pennsylvania Legal Aid Network**
1-800-322-7572 (palegalaid.net)

# Chapter 14: Medicare Compliance Requirements

**Purpose:** This chapter provides Jefferson Health Plans Medicare Advantage network providers with the information and resources they will need to understand and fulfill General Compliance Program and FWA requirements related to our Medicare Advantage products.

**Topics:** Important topics from this chapter include:

- First-Tier, Downstream and Related entities (FDRs)
- Compliance Program Requirements
- Health Plan Code of Business Conduct
- Health Plan Compliance Program
- Code of Conduct and Compliance Policy Distribution Requirements
- General Compliance Program and FWA Training Resources



# Overview

This chapter provides a summary of Medicare Compliance Program requirements as they relate to Jefferson Health Plans Medicare Advantage network providers.

## First-Tier, Downstream and Related entities (FDRs)

The Centers for Medicare & Medicaid Services (CMS) refers to our contracted partners as First-Tier, Downstream and Related entities (FDRs).

Examples of FDRs include:

- Field marketing organizations
- Agents
- Hospitals
- Providers
- Independent Practice Associations (IPA)
- Pharmacies
- Pharmacy benefit managers
- Claim administration vendors
- Fulfillment vendors
- Other vendors who help us deliver benefits

### First Tier and Downstream Classification

Health care providers that are directly contracted with Jefferson Health Plans to provide Medicare health care services to Jefferson Health Plans Medicare Advantage enrollees are considered to be Jefferson Health Plans first tier entities, or FDRs (First Tier, Downstream, Related entities). For example, hospitals, health care facilities, provider groups, doctor's offices and clinical laboratories that are directly contracted with Jefferson Health Plans for its Medicare Advantage plans are considered to be Jefferson Health Plans First Tier Entities.



Parties that enter into written arrangements with the Jefferson Health Plans First Tier Entity examples mentioned above to perform Jefferson Health Plans Medicare Advantage related services are considered to be downstream entities.

## Compliance Program Requirements

As a Medicare Advantage plan sponsor, Jefferson Health Plans must ensure that FDRs performing delegated administrative or health care service functions related to its Medicare Advantage program are familiar and comply with General Medicare Compliance Program and Fraud, Waste and Abuse requirements described in the Jefferson Health Plans Code of Business Conduct (COBC) and Medicare Compliance Program documents.

In order to fulfill General Medicare Compliance Program requirements, Jefferson Health Plans Health Care Provider First Tier Entities must:

- Adopt and comply with Jefferson Health Plans COBC and Compliance Policies or have their own materially similar versions.
- Ensure that Jefferson Health Plans Code of Business Conduct and Compliance Program documents or their own materially similar versions are distributed to all personnel involved with Jefferson Health Plans Medicare Advantage business (including downstream

entity personnel, when applicable) within 90 days of contracting, upon revision and annually thereafter.

- Provide evidence of Code of Conduct and Compliance Policy distribution to Jefferson Health Plans upon request.

*Note: Jefferson Health Plans maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS. CMS may hold Jefferson Health Plans accountable for the failure of its FDRs to comply with Medicare program requirements and in turn Jefferson Health Plans will hold its providers and FDRs to all of these applicable requirements.*

## General Compliance Program and FWA Training Resources

Jefferson Health Plans FDRs must ensure that all personnel assigned to perform Jefferson Health Plans Medicare Advantage services know:

- How the compliance program operates and;
- How to identify and report issues of Medicare Advantage Program non-compliance and Fraud, Waste and Abuse (FWA).

While this may be accomplished through Code of Conduct and Compliance Policy distribution, FDRs may also conduct General Compliance Program and FWA training with their employees as needed or upon Jefferson Health Plans assignment.

**CMS MLN website:**
**cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining**.

# Chapter 15: Member Rights and Responsibilities

**Purpose:** This chapter provides a description of the member's rights and responsibilities for our Medicaid, Medicare, CHIP and Individual and Family Plans lines of business.

**Topics:** Important topics from this chapter include:

Member Rights & Responsibilities

- Jefferson Health Plans EverWell and Jefferson Health Plans CHIP
- Jefferson Health Plans Medicare Advantage
- Jefferson Health Plans Individual and Family Plans



# Jefferson Health Plans EverWell and Jefferson Health Plans CHIP Member Rights and Responsibilities

Jefferson Health Plans EverWell and Jefferson Health Plans CHIP members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by us, its participating providers or other State agencies. Our members also have the right to make health care decisions without feeling as though we are restraining, isolating, influencing, bullying, punishing or retaliating against them.

We, and our network of providers, do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

Below is a statement of the rights provided to our members. These rights must be honored by us, our network providers and their staff.

## Member Rights

### Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by our staff and network providers.
- To get information about our organization, our services, our practitioners and providers and members rights and responsibilities in a way that they can easily understand and find help when they need it.
- To pick the network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without our approval.
- To get information that they can easily understand and talk to their providers about their treatment options, without any interference from us.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.
- To talk with providers confidently about appropriate medically necessary treatment options, regardless of cost or benefit coverage, and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to those records.
- To ask for a second opinion.
- To file a grievance if they disagree with our decision that a service is not medically necessary.
- To file a complaint if they are unhappy about the care or treatment they have received.
- To ask for a DHS Fair Hearing.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that we or a provider does not cover because of moral or religious objections and about how to get those services.

- To exercise their rights without it negatively affecting the way we, DHS and network providers treat them.
- To create an advanced directive. See Section 6 of the Member Handbook for more information.
- To make recommendations about the rights and responsibilities of our Members.

### Member Responsibilities

Members also have responsibilities, including the duty to work with their health care service providers. Here are some suggestions for our Members to ensure that Members and providers work together:

- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Understand their health problems and be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about our coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless we approve an out-of-network provider.
- Get a referral from their PCP to see a specialist.
- Respect other patients, health plan staff, provider staff, and provider workers.
- Make a good-faith effort to pay their co-payments.
- Report suspected or actual fraud and abuse to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

**If members believe they are being treated unfairly or their rights are not being respected:**

Call Member Relations at the numbers below:

**Jefferson Health Plans EverWell Member Relations**
1-800-553-0784 (TTY 1-877-454-8477)
24 hours a day/7 days a week

**Jefferson Health Plans CHIP Member Relations**
1-888-888-1211 (TTY 1-877-454-8477)
24 hours a day/7 days a week

## Jefferson Health Plans Medicare Advantage Member Rights & Responsibilities

### Member Rights

We have informed our Members that as a Jefferson Health Plans Medicare Advantage member, they have certain rights, including:

- We must provide information in a way that works for the Member (such as in languages other than English, in Braille, in large print, or other alternate formats).
- To be treated with fairness and respect at all times.
- We must ensure timely access to covered services and drugs.
- We must protect the privacy of personal health information.
- We must give information about the plan, our network of providers, and covered services.
  - This includes:
    - Information about coverage and the rules that must be followed when using our coverage.
    - Information about why something is not covered and what can be done about it.

- We must support the Member's right to make decisions about their care.

– This includes:

  - Having the right to know treatment options and participate in decisions about health care.

  - Having the right to give instructions about what is to be done if a Member is not able to make their own medical decisions.

  - Having the right to make complaints and to ask us to reconsider decisions we have made.

**If members believe they are being treated unfairly or their rights are not being respected:**

If it is about discrimination, call the U.S. Department of Health and Human Services Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

If it's not about discrimination, call Member Relations at the numbers below:

**Jefferson Health Plans Medicare Advantage Member Relations**
1-866-901-8000 (TTY 1-877-454-8477)

From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

**Call the State Health Insurance Assistance Program, Apprise,** at 1-800-783-7067.

Or, call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048

## Member Responsibilities

Members also have some responsibilities as a member of the plan, including:

- Becoming familiar with covered services and the rules that must be followed to get these covered services.
- Tell us if of any other health insurance coverage or prescription drug coverage in addition to our plan.
- Tell their doctor and other health care providers that they are enrolled in our plan.
- Help their doctors and other providers help them by giving them applicable information, asking questions, and following through on their care.
- Be considerate of providers and respect the rights of other patients.
- Pay what is owed for their Medicare coverage and the services received.
- Give notice when they move.

Members can call us at the phone numbers below for help if they have questions or concerns.

**Jefferson Health Plans Medicare Advantage Member Relations**
1-866-901-8000 (TTY 1-877-454-8477)

From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday

# Jefferson Health Plans Individual and Family Plans

## Member Rights and Responsibilities

- Jefferson Health Plans members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by Jefferson Health Plans, its participating providers or other State agencies. Our members also have the right to make health care decisions without feeling as though Jefferson Health Plans is restraining, isolating, influencing, bullying, punishing or retaliating against them.
- Jefferson Health Plans and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.
- Below is a statement of the rights provided to our members. These rights must be honored by Jefferson Health Plans, our network providers and their staff. It is your obligation and duty as a Jefferson Health Plans provider to adhere to and comply with these standards and upholding our Members Rights.

## Member Rights

Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by Jefferson Health Plans staff and network providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about Jefferson Health Plans, its services, and the doctors and other providers that treat them.
- To pick the network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without Jefferson Health Plans' approval.
- To get information that they can easily understand and talk to their providers about their treatment options, without any interference from Jefferson Health Plans.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.
- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to those records.
- To ask for a second opinion.
- To file a grievance if they disagree with Jefferson Health Plans' decision that a service is not medically necessary.
- To file a complaint if they are unhappy about the care or treatment they have received.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that Jefferson Health Plans or a provider does not cover because of moral or religious objections and about how to get those services.
- To exercise their rights without it negatively affecting the way DHS, Jefferson Health Plans, and network providers treat them.
- To create an advanced directive. See Member Handbook for more information.
- To make recommendations about the rights and responsibilities of our Members.

## Member Responsibilities

Members also have responsibilities, including the duty to work with their health care service providers. Below are the responsibilities we share with our Members to ensure that Members and providers work together:

- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about Jefferson Health Plans coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless Jefferson Health Plans approves an out-of-network provider.
- Respect other patients, health plan staff, provider staff, and provider workers.

**If members believe they are being treated unfairly or their rights are not being respected:**

Call Member Relations at the number below:

**Jefferson Health Plans Individual and Family Plans Member Relations**
1-833-422-4690 (TTY 1-877-454-8477)

From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday

# Chapter 16: Appendix

**Purpose:** This chapter includes valuable information regarding a variety of topics and resources.

**Topics:** Important topics from this chapter include:

- DHS Domestic Violence Initiatives
- CMS-1500 Place of Service Indicators
- Protections for Individuals Limited English Proficiency (LEP)
- Jefferson Health Plans Individual and Family Plans Preventive Benefit Schedule
- Healthy Kids Program Periodicity Schedule & Coding Matrix
- Our Medical Record Documentation Standards
- Americans with Disabilities Act (ADA)
- Additional contact information



## DHS Domestic Violence Initiatives

We support the Pennsylvania Department of Human Services (DHS) initiatives for victims of domestic violence.

For more information on how to support domestic violence victims and survivors, visit:

- **The Department of Human Services:** (pa.gov/services/dhs/get-domestic-violence-support-)
- **Pennsylvania Medical Society:** pamedsoc.org or 1-800-228-7823)
- **National Domestic Violence Hotline:** thehotline.org/ or 1-800-799-7233)

## CMS-1500 Place of Service Codes

Please visit cms.gov/Medicare/Coding/place-of-service-codes/ for the list of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes.

## Limited English Proficiency (LEP)

Providers should visit the website below for tips on how to effectively communicate using interpreters:

**"Interpret Tool: Working with Interpreters in Clinical Settings,"** DHHS Office for Minority Health, Language Access Resources. acf.gov/sites/default/files/documents/otip/hhs_clas_interpret_tool.pdf

### Additional Information

To help providers learn more about culturally and linguistically appropriate health care, we recommend review of the following material:

**"The Guide to Providing Effective Communication and Language Assistance Services":** This is a free, self-directed training course for physicians and other health care professionals grounded in the HHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Access the website at thinkculturalhealth.hhs.gov/education/communication-guide.

Call the **Provider Services Helpline** at 1-888-991-9023 for more information.

# Jefferson Health Plans Individual and Family Plans Preventive Benefit Schedule

| Preventive Care Services for Adults | |
|---|---|
| **Visits** | |
| **Preventive exams**<br>Services that may be provided during the preventive exam include but are not limited to the following:<br>• High blood pressure screening<br>• Behavioral counseling for skin cancer<br>• Obesity Screening<br>• Unhealthy drug use screening | One exam annually for all adults |
| **Screenings** | |
| **Abdominal aortic aneurysm (AAA) screening** | Once in a lifetime for asymptomatic males aged 65 to 75 years with a history of smoking |
| **Colorectal cancer screening** | Adults aged 45 to 75 years using any of the following tests:<br>• Fecal occult blood testing: once a year<br>• Highly sensitive fecal immunochemical testing: once a year<br>• Flexible sigmoidoscopy: once every five years<br>• CT colonography: once every five years<br>• Stool DNA testing: once every three years<br>• Colonoscopy: once every 10 years |
| **Depression screening** | Annually for all adults |
| **Hepatitis B virus (HBV) screening** | All asymptomatic adults at high risk for HBV infection |
| **Hepatitis C Virus (HCV) screening** | All asymptomatic adults |
| **High Blood Pressure Screening** | • Adults aged 18 years or older with increased risk once a year<br>• Adults aged 18 to 39 years with no other risk factors once every 3 to 5 years<br>• Adults aged 40 years once a year |
| **Human immunodeficiency virus (HIV) screening** | All adults |

| Preventive Care Services for Adults | |
|---|---|
| **Latent tuberculosis infection screening** | Asymptomatic adults ages 19 years or older at increased risk for tuberculosis |
| **Lipid disorder screening** | Adults 40 years of older once every 5 years |
| **Lung cancer screening** | Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years |
| **Syphilis infection screening** | All adults at increased risk for syphilis infection |
| **Unhealthy alcohol use screening and behavioral counseling interventions** | • Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence<br>• Behavioral counseling in a primary care setting for individuals with a positive screening result |
| **Therapy and Counseling** | |
| **Behavioral counseling for prevention of sexually transmitted infections** | All sexually active adults |
| **Behavioral interventions for weight loss** | Behavioral intervention for adults with a body mass index (BMI) of 30kg/m2 or higher |
| **Exercise interventions for the prevention of falls** | Community-dwelling adults ages 65 years and older with an increased risk of falls |
| **Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention** | Adults ages 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors |
| **Nutritional counseling for weight management** | 6 visits per year |
| **Tobacco use counseling** | All adults who use tobacco products |
| **Work-up and follow-up services for pre-exposure prophylaxis for the prevention of HIV** | Adults at high risk for HIV infection |
| **Medications** | |
| **Low dose aspirin** | Adults aged 50 to 59 years for the primary prevention of cardiovascular disease and colorectal cancer |
| **Pre-exposure prophylaxis for the prevention of HIV infection** | Adults at high risk for HIV infection |
| **Prescription bowel preparation** | Adults ages 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure (that is, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy) |
| **Statin** | Adults ages 40 to 75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10% |

| Preventive Care Services for Adults | |
|---|---|
| **Tobacco cessation medication** | All adults who use tobacco products |
| **Adult Immunization Schedule** | |
| JeffersonHealthPlans.com/Home/Providers/Clinical-Resources/Preventive-Guidelines/ | |

| Preventive Care Services for Females, Including Pregnant Females | |
|---|---|
| **Visits** | |
| **Prenatal care visits**<br>Services that may be provided during the prenatal care visits include, but are not limited to the following:<br>• Preeclampsia Screening | For all pregnant females |
| **Well-woman visits**<br>Services that may be provided during the well-woman visit include but are not limited to the following:<br>• BRCA-related cancer risk assessment<br>• Discussion of chemoprevention for breast cancer<br>• Intimate partner violence screening<br>• Primary care interventions to promote and support breastfeeding<br>• Recommended preventive preconception and prenatal care services<br>• Urinary incontinence screening | At least annually |
| **Screenings** | |
| **Anxiety screening** | All females |
| **Bacteriuria screening** | All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later |
| **Counseling interventions to prevent perinatal depression** | Pregnant or postpartum females at increased risk for perinatal depression without a current diagnosis of depression. 20 sessions over a 70-week period |

| Preventive Care Services for Females, Including Pregnant Females | |
|---|---|
| **BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing** | • Genetic counseling for asymptomatic females with an ancestry associated with the BCRA gene mutations, personal history or family history or a BRCA-related cancer<br>• BRCA mutation testing, as indicated, following genetic counseling |
| **Breast cancer screening (2D or 3D mammography) Includes any additional imaging (magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation needed to complete the screening process or to address findings on initial screening mammography** | All females aged 40 years and older |
| **Cervical cancer screening (Pap test)** | • Ages 21 to 65: Every three years<br>• Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval |
| **Chlamydia screening** | Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection |
| **Diabetes mellitus screening after pregnancy** | Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus |
| **Depression screening** | All pregnant and post-partum females |
| **Gestational diabetes mellitus screening** | Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes |
| **Gonorrhea screening** | Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection |
| **Hepatitis B virus (HBV) screening** | All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection |
| **Human immunodeficiency virus (HIV) screening** | All pregnant females |
| **Human papillomavirus (HPV) screening** | • Ages 30 and older: Every five years<br>• Ages 30 to 65: Every five years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval |

| Preventive Care Services for Females, Including Pregnant Females | |
|---|---|
| **Osteoporosis (bone mineral density) screening** | • Every two (2) years for females younger than 65 years who are at increased risk for osteoporosis<br>• Every two (2) years for females aged 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition |
| **Patient Navigation Services for Breast and Cervical Cancer Screening** | All females receiving breast and/or cervical cancer screening services |
| **RhD incompatibility screening** | All pregnant females and follow-up testing for females at higher risk |
| **Syphilis screening** | • All pregnant females at first prenatal visit<br>• For high-risk pregnant females, repeat testing in the third trimester and at delivery<br>• Females at increased risk for syphilis infection |
| **Tobacco Use Counseling** | All pregnant females who smoke tobacco products |
| **Unhealthy alcohol use screening and behavioral counseling interventions** | • Screening for all pregnant females<br>• Behavioral counseling in a primary care setting with a positive screening results |
| **Medications** | |
| **Breast cancer chemoprevention** | Asymptomatic females aged 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention |
| **Folic acid** | Daily folic acid supplements for all females planning for or capable of pregnancy |
| **Low dose Aspirin** | Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation |
| **Miscellaneous** | |
| **Breastfeeding supplies/support/counseling** | All females with reproductive capacity |
| **Reproductive education and counseling, contraception, and sterilization** | All females with reproductive capacity |

| Preventive Care Services for Children | |
|---|---|
| **Visits** | |
| **Pre-birth exams** | All expectant parents for the purpose of establishing a pediatric medical home |
| **Preventive exams**<br><br>Services that may be provided during the preventive exam include but are not limited to the following:<br>• Behavioral counseling for skin cancer prevention<br>• Blood pressure screening<br>• Congenital heart defect Screening<br>• Counseling and education provided by health care providers to prevent initiation of tobacco use<br>• Developmental surveillance<br>• Dyslipidemia risk Assessment<br>• Hearing risk assessment for children 29 days or older<br>• Height, weight, and body mass index measurements<br>• Obesity screening<br>• Psychosocial/behavioral assessment | All children up to 21 years of age, with preventive exams provided at:<br>• 3-5 days after birth<br>• By 1 month<br>• 2 months<br>• 4 months<br>• 6 months<br>• 9 months<br>• 12 months<br>• 15 months<br>• 18 months<br>• 24 months<br>• 30 months<br>• 3 years-21 years: annual exams |
| **Screenings** | |
| **Alcohol, tobacco, and drug use screening and behavioral counseling intervention** | • Annually for all children aged11 years and older<br>• Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse |
| **Autism and developmental screening** | All children |
| **Bilirubin screening** | All newborns |
| **Chlamydia screening** | All sexually active children up to age 21 years |
| **Depression screening** | Annually for all children aged 12 years to 21 years |
| **Dyslipidemia screening** | Following a positive risk assessment or in children where laboratory testing is indicated |
| **Gonorrhea screening** | All sexually active children up to age 21 years |
| **Hearing screening for newborns** | All newborns |

| Preventive Care Services for Children | |
|---|---|
| **Hearing screening for children 29 days or older** | Following a positive risk assessment or in children where hearing screening is indicated |
| **Hepatitis B virus (HBV) screening** | All asymptomatic adolescents at high risk for HBV infection |
| **Human immunodeficiency virus (HIV) screening** | All children |
| **Iron deficiency Screening** | All children |
| **Lead poisoning screening** | All children at risk of lead exposure |
| **Newborn metabolic screening panel (For example, congenital hypothyroidism, hemoglobinopathies [sickle cell disease], phenylketonuria [PKU])** | All newborns |
| **Syphilis screening** | All sexually active children up to age 21 years |
| **Vision screening** | All children up to age 21 years |
| **Additional Screening Services and Counseling** | |
| **Behavioral counseling for prevention of sexually transmitted infections** | Semiannually for all sexually active adolescents |
| **Obesity screening and behavioral counseling** | • Screening is part of the preventive exam for children ages 6 years and older.<br>• Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater |
| **Medications** | |
| **Fluoride** | Oral fluoride for children aged 6 months to 16 years whose water supply is deficient in fluoride |
| **Prophylactic ocular topical medication for gonorrhea** | All newborns within 24 hours after birth |
| **Miscellaneous** | |
| **Fluoride varnish application** | Every three months for all infants and children starting age of primary tooth eruption to 5 years of age |
| **Tuberculosis testing** | All children up to age 21 years |
| **Immunizations** (Note: for age 19 to 21 years, refer to the adult schedule listed above) | |
| Children Immunization Schedule: JeffersonHealthPlans.com/Home/Providers/Clinical-Resources/Preventive-Guidelines/ | |

## Periodicity Schedule & Coding Matrix

Please visit our **EPSDT/Bright Futures** webpage for the latest EPSDT Periodicity Schedule and Coding Matrix and for the most current **Care Guidelines**.

All sexually active patients should be screened for sexually transmitted infections (STI). All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first). For more information, please our website.

Dental Periodicity Schedule: Please visit the **American Academy of Pediatric Dentistry** periodicity of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents.

## Our Medical Record Documentation Standards

Consistent and complete documentation in the medical record is an essential component of quality patient care. Our standards have been developed using the standards of the NCQA, DHS, PID, CMS and the Pennsylvania Medical Society guidelines for documentation. Following are the standards against which the medical record is measured.

- Each page in the record contains the patient's name or ID number
- Each record contains appropriate biographical or personal data
- Each author is identified on each entry
- All entries are dated
- The record is legible to someone other than the writer
- There is a completed problem list
- A listing of medications is easily found and lists all medications currently used
- Allergies and adverse reactions to medications are prominently noted
- There is a pertinent history and physical exam
- Lab and other studies are ordered as appropriate
- Working diagnoses are consistent with findings
- Plans of action and treatment are consistent with findings
- There is evidence of patient teaching
- There are dates for return visits or other follow-up plans
- There is documentation and follow-up of "no-shows"
- Problems from previous visits are addressed
- There is evidence of appropriate use of consultants
- There is continuity and coordination of care between PCPs and specialists
- Consultant summaries, lab and imaging study results, and surgical procedure summaries reflect PCP review
- Care appears medically appropriate for the diagnosis or conditions
- There is a completed immunization record
- Preventive services are appropriately used
- There is documentation of discussion of a living will or advance directives
- There is documentation of discussions about domestic violence and safety at home. Please visit the **Domestic Violence** section of the **Appendix** for additional resources.
- Phone calls to and from the patient are documented

- Evidence of hospital discharge summary in medical record
- Evidence of review of hospital discharge by physician
- Evidence of communication between home care agency and physician in medical record

## Additional Medical Records Requirements

- All records shall be maintained in an accurate and timely manner in accordance with the record-keeping procedures, applicable laws, regulations, and regulating entity requirements, including, but not limited to the DHS, DOH, PID, and/or CMS requirements related to medical records.
- All medical records must be legible, signed, and dated and must be maintained for ten (10) years from last date of service or as required by federal law. Payer and the provider agree that until the expiration of ten (10) years after the furnishing of any service pursuant to this Agreement, or until any ongoing audits by the following entities are completed, whichever is longer, Payer and the Provider shall make available, upon written request of DHS, the Commonwealth, the Secretary of Health and Human Services or the Controller General of the United States, or any of their duly authorized representatives, copies of this Agreement and any books, documents, records, medical records, other patient care documentation, and other data that is necessary to certify the nature and extent of revenues, expenditures, and other financial activity arising in connection with this Agreement.
- The provider will abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health information.
- The provider must safeguard the privacy of any information that identifies a particular member and have procedures for how information will be shared and disclosed within and outside of the provider's office. Providers will ensure that medical information is released only in accordance with applicable federal or state law or pursuant to court orders or subpoenas.
- The provider shall make, at his or her own expense, all records (i.e., any books, contracts, medical records, patient care documentation) available for audit, review or evaluation by all regulatory entities and its designated representatives or federal agencies in such detail as is reasonably necessary for the determination of the member's eligibility for medical services and for utilization management and quality improvement. Access shall be provided either onsite at the Health Plan or at the provider's office during normal business hours or through the mail or secured fax. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.
- Each member is entitled to have timely access to his or her medical records in accordance with federal and state laws. Members also have a right to have a copy of their medical record. Members may be charged a nominal fee to have medical records copied. Members can call our Member Relations at 1-800-553-0784 (Jefferson Health Plans EverWell), 1-888-888-1211 (Jefferson Health Plans CHIP), 1-833-422-4690 (Jefferson Health Plans Individual and Family Plans) or 1-866-901-8000 (Jefferson Health Plans Medicare Advantage) for help. They can also call their physician's office directly. The Member Relations staff will advise members that they must sign a release form to obtain their medical record or have a copy sent to a new doctor. Providers cannot charge the member for a copy of his or her medical record sent directly to another provider.

# Americans with Disabilities Act (ADA)

Section 504 of the Rehabilitation Act of 1973 states that "No otherwise qualified handicapped individual in the United States...shall, solely by reason of...handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Section 504 applies to programs or activities that receive federal financial assistance. Title II of the ADA covers all the services, programs and activities conducted by public entities (state and local governments, departments, agencies, etc.), including licensing. For more information regarding the ADA, go to the U.S. Department of Health and Human Services website at **hhs.gov/civil-rights/for-individuals/disability/index.html**.

We require practitioners to abide by ADA requirements.

- Handicapped parking spaces with curb cuts, if applicable
- Handicapped accessible restrooms
- Access ramps where applicable
- Access ramps to entrance of the building
- Access ramps to provider office, if different entrance than building (e.g., hospital)

If a practitioner's site does not meet ADA standards, there are reasonable alternatives to accommodate those with disabilities. These include:

- Home visits
- Access at another site that meets ADA requirements
- Bathroom facilities elsewhere in the building that meet ADA requirements or portable bathroom facilities

# Additional Contact Information

The below listing includes contact information for other organizations of interest to participating providers.

## Behavioral Health Services

**CHIP, Medicare Advantage and Individual and Family Plans:** 1-877-614-0484 (Optum) Monday – Friday 8 a.m. to 8 p.m. ET.

**Medicaid:** Visit **dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx**

## Vendor Information

**Avesis (Dental):** 1-800-952-6674

**Davis Vision:** 1-800-773-2847

**ECHO Health (Electronic funds transfer and remittance advice):** 1-888-834-3511
**ECHO Health:** **echohealthinc.com/provider**

**EviCore (Radiology and PT/OT/ST and other authorizations):** 1-888-693-3211

**Medical Assistance Transportation Program (MATP) County Contact List:**
**matp.pa.gov/CountyContact.aspx**

## Claims Submissions

Please note that Jefferson Health Plans recommends electronic claims submissions.

**EDI (Electronic Data Interchange) Support:**
**edi@jeffersonhealthplans.com**

For information on claims filing instructions, please see **Chapter 12**, **Provider Billing and Reimbursement**.

## Claims Reconsiderations

Claims reconsideration requests can be submitted through the HealthTrio provider portal: **JeffersonHealthPlans.com/Providers/Provider-Portals**

### Patient Safety Reporting Hotline

**Use for confidential reporting of preventable, serious adverse events:** 1-855-218-2314

### DHS Toll-Free MA Provider Compliance Hotline

**MA Provider Compliance Hotline:**
1-866-379-8477 (8:30 a.m. to 3:30 p.m.)

### Report Medicare, Medicaid, CHIP or other potential Fraud, Waste or Abuse, or Suspicious Activity

**Our SIU Hotline (reports can be made anonymously):** 1-866-477-4848

**The CMS Medicare Hotline:** 1-800-MEDICARE (1-800-633-4227)

**The Department of Human Services Medicaid Hotline:** 1-844-DHS-TIPS (1-866-379-8477)

### PA-NEDSS

**PA-NEDSS New User Guide:**
nedss.state.pa.us/nedss/FILES/V15/New%20User%20Guide.pdf

**Listing of PA reportable conditions:**
health.pa.gov/topics/Reporting-Registries/Pages/Reportable-Diseases.aspx

**Pennsylvania Code website:**
pabulletin.com/index.asp

### Advance Directives

**American Academy of Family Physicians:**
aafp.org

**Patient information:** familydoctor.org

**American College of Physicians:** acponline.org

**American Medical Association:** ama-assn.org

## Additional Resources

**Pennsylvania Department of Human Services (DHS):**

Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105-2675

**Women, Infants and Children (WIC) Nutrition Program:** 1-800-WINS (1-800-942-9467)

**Pennsylvania Health Law Project**
Fax: 717-236-6311

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