Provider Manual | June 2025

Primary Care | Specialist | Ancillary | Hospital

AmeriHealth Caritas®
Pennsylvania

Coverage by AmeriHealth First.

KF_254503700-2

Table of Contents

Introduction

About AmeriHealth Caritas Pennsylvania

Who We Are

AmeriHealth Caritas Pennsylvania are members of the AmeriHealth Caritas Family of Companies that is headquartered in Philadelphia, Pennsylvania. AmeriHealth Caritas Pennsylvania is based in Harrisburg, Pennsylvania and serves Medical Assistance recipients in 62 Pennsylvania counties.

AmeriHealth Caritas Pennsylvania serves Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, and York Counties.

Our mission:

We Help People:
Get Care
Stay Well
Build Healthy Communities
We have a special concern for those who are poor.

Our Values:

Our service is built on these values:

Advocacy

Care of the Poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

All images are under license for illustrative purposes only. Any individual depicted is a model.

Plan Name	Provider Services Phone Number	Website Address
AmeriHealth Caritas Pennsylvania	1-800-521-6007	www.amerihealthcaritaspa.com

Important Contact Numbers	
Department	**AmeriHealth Caritas Pennsylvania**
Behavioral Health Services	See Table Below
Bright Start® Maternity Program	Phone: 1-877-364-6797 Fax: 1-866-755-9935
Care Management/ HIV/AIDS Program	Phone: 1-877-693-8271 Fax: 1-866-755-0030
Change Healthcare Provider Support Line	Phone: 1-800-527-8133
ChildLine (DHS number to report suspected child abuse)	Phone: 1-800-932-0313
Clinical Services	Phone: 1-800-521-6622 Fax: 1-866-755-9936
CONNECT Hotline (PA Early Intervention)	Phone: 1-800-692-7288
Contracting	Phone: 1-866-546-7972 Fax: 1-717-651-1673
Credentialing	Phone: 1-800-642-3510, option 2 Fax: 1-215-863-6369
Dental Services	Phone: 1-855-343-7401
Discharge Planning/ SNF	Phone: 1-800-521-6622 Fax 1-866-755-9936
DME Prior Authorization Services	Phone: 1-800-521-6622 Fax:1-866-755-9841
EDI Technical Support	Phone: 1-877-234-4272
Electronic Billing Questions	Phone: 1-877-234-4272
Enhanced Member Supports Unit	Phone: 1-800-684-5503
EPSDT Unit (Pediatric Preventive Health Care Program)	Phone: 1-888-765-6388

	Fax: 1-866-208-8145
ER Hospital Admission	Phone: 1-800-521-6622
Family Planning Services	Phone: 1-888-991-7200
Fraud and Abuse Hotline	Phone: 866-833-9718
Home care/ Infusion/ Hospice	Phone: 1-800-521-6622 Fax: 1-866-755-9949
Maternity Data	Phone: 1-800-521-6622
Medical Assistance Transportation Program (MATP)	http://matp.pa.gov/
Member Services	Phone: 1-888-991-7200
NaviNet Customer Service	www.navinet.net Phone: 1-888-482-8057
OB Deliveries/Admission Notification Forms	Phone: 1-800-521-6622 Fax: 1-888-742-2377
Outpatient Radiology Authorizations- Evolent Specialty Services, Inc. (Evolent)	www.radmd.com Phone: 1-800-424-5657
Outpatient Therapy, including Chiropractic	Phone: 1-800-521-6622
Outreach and Health Education Programs	Phone: 1-877-693-8271
PA DHS OMAP Services Line	Phone: 1-800-537-8862
PA Enrollment Services	Phone: 1-800-440-3989
Peer-to-Peer Hotline	Phone:1-877-693-8480
Pennsylvania Eligibility Verification System (EVS)	Phone: 1-800-766-5387
Pennsylvania Tobacco Cessation Information Quitline	Phone: 1-800-784-8669
Perform Rx Pharmacy Services/Pharmacy Prior Authorizations	Phone:1-866-610-2774 Fax: 1-888-981-5202 Online: www.amerihealthcaritaspa.com→ Pharmacy → Prior Authorization
Prior Authorization Services	Phone: 1-800-521-6622 Fax: 1-866-755-9949
Provider Claims Services Unit	Phone: 1-800-521-6007
Provider Services	Phone: 1-800-521-6007
Quest Diagnostics (Lab)	Phone: 1-866-697-8378 www.questdiagnostics.com

Rapid Response and Outreach	Phone: 1-800-684-5503
TTY-Telecommunications for the Hearing Impaired	Phone: 1-888-987-5704
Utilization Management	Phone: 1-800-521-6622
Vision Services-Davis Vision	Phone: 1-800-773-2847 www.davisvision.com
24-Hour Nurse Hotline	Phone: 1-866-566-1513

Behavioral Health and Substance Abuse by County

County	Behavioral Health Plan	Phone Number
Adams	Community Care Behavioral Health	1-888-251-2224
Allegheny	Community Care Behavioral Health	1-888-251-2224
Armstrong	Carelon Health of PA, Inc.	1-877-615-8503
Beaver	Carelon Health of PA, Inc.	1-877-615-8503
Bedford	Community Care Behavioral Health	1-888-251-2224
Berks	Community Care Behavioral Health	1-888-251-2224
Blair	Community Care Behavioral Health	1-888-251-2224
Bradford	Community Care Behavioral Health	1-888-251-2224
Butler	Carelon Health of PA, Inc.	1-877-688-5971
Cambria	Magellan Behavioral Health of PA	1-866-780-3368
Cameron	Community Care Behavioral Health	1-888-251-2224
Carbon	Community Care Behavioral Health	1-888-251-2224
Centre	Community Care Behavioral Health	1-888-251-2224
Clarion	Community Care Behavioral Health	1-888-251-2224

Clearfield	Community Care Behavioral Health	1-888-251-2224
Clinton	Community Care Behavioral Health	1-888-251-2224
Columbia	Community Care Behavioral Health	1-888-251-2224
Crawford	Carelon Health of PA, Inc.	1-877-615-8503
Cumberland	PerformCare	1-888-700-7370
Dauphin	PerformCare	1-888-700-7370
Elk	Community Care Behavioral Health	1-888-251-2224
Erie	Community Care Behavioral Health	1-888-251-2224
Fayette	Carelon Health of PA, Inc.	1-877-615-8503
Forest	Community Care Behavioral Health	1-888-251-2224
Franklin	PerformCare	1-888-700-7370
Fulton	PerformCare	1-888-700-7370
Greene	Community Care Behavioral Health	1-888-251-2224
Huntingdon	Community Care Behavioral Health	1-888-251-2224
Indiana	Carelon Health of PA, Inc.	1-877-615-8503
Jefferson	Community Care Behavioral Health	1-888-251-2224
Juniata	Community Care Behavioral Health	1-888-251-2224
Lackawanna	Community Care Behavioral Health	1-888-251-2224
Lancaster	PerformCare	1-888-700-7370
Lawrence	Carelon Health of PA, Inc.	1-877-615-8503
Lebanon	PerformCare	1-888-700-7370
Lehigh	Magellan Behavioral Health of PA	1-866-780-3368
Luzerne	Community Care Behavioral Health	1-888-251-2224

Lycoming	Community Care Behavioral Health	1-888-251-2224
McKean	Community Care Behavioral Health	1-888-251-2224
Mercer	Carelon Health of PA, Inc.	1-877-615-8503
Mifflin	Community Care Behavioral Health	1-888-251-2224
Monroe	Community Care Behavioral Health	1-888-251-2224
Montour	Community Care Behavioral Health	1-888-251-2224
Northampton	Magellan Behavioral Health of PA	1-866-780-3368
Northumberland	Community Care Behavioral Health	1-888-251-2224
Perry	PerformCare	1-888-700-7370
Pike	Community Care Behavioral Health	1-888-251-2224
Potter	Community Care Behavioral Health	1-888-251-2224
Schuylkill	Community Care Behavioral Health	1-888-251-2224
Snyder	Community Care Behavioral Health	1-888-251-2224
Somerset	Community Care Behavioral Health	1-888-251-2224
Sullivan	Community Care Behavioral Health	1-888-251-2224
Susquehanna	Community Care Behavioral Health	1-888-251-2224
Tioga	Community Care Behavioral Health	1-888-251-2224
Union	Community Care Behavioral Health	1-888-251-2224
Venango	Carelon Health of PA, Inc.	1-877-615-8503
Warren	Community Care Behavioral Health	1-888-251-2224
Washington	Carelon Health of PA, Inc.	1-877-615-8503

Wayne	Community Care Behavioral Health	1-888-251-2224
Westmoreland	Carelon Health of PA, Inc.	1-877-615-8503
Wyoming	Community Care Behavioral Health	1-888-251-2224
York	Community Care Behavioral Health	1-888-251-2224

Important Definitions	
Abuse	Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFA, Agreement, and the requirements of state or federal regulations) for healthcare in a managed care setting. The Abuse can be committed by the Plan, Subcontractor, Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, the Plan, a Subcontractor, or Provider.
Electronic Benefits Transfer (EBT) ACCESS Card	An identification card issued by Pennsylvania Department of Human Services (DHS) to each individual eligible for Medical Assistance. The card is used by Providers to verify the individual's MA eligibility and specific covered benefits.
Behavioral Health Managed Care Organization (BH-MCO)	An entity directly operated by the county government or licensed by the Commonwealth as a risk-bearing Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), which manages the purchase and provision of behavioral health services under a contract with DHS.
Capitation	A fixed per capita amount that the Plan pays monthly to a Network Provider for each Member identified as being in their capitation group, whether or not the Member received services.
Care Management Services	Services which will assist individuals in gaining access to necessary medical, social, educational and other services.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.

Certified Nurse Midwife	An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. §§171-176.
Certified Registered Nurse Practitioner (CRNP)	A professional nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.
Claim	A bill from a provider of a medical service or product that is assigned a unique identifier (i.e. claim reference number.) A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.
Clean Claim	A Claim that can be processed without obtaining additional information from the provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the Plan's Claims system. Claims under investigation for Fraud or abuse or under review to determine if they are Medically Necessary are not Clean Claims.
Client Information System (CIS)	The Department's database of Recipients. The database contains demographic and eligibility information for all Recipients.
Complaint	A dispute or objection regarding a participating Healthcare provider or the coverage, operations, or management of a Plan, which has not been resolved by the Plan and has been filed with the Plan or with PID's Bureau of Managed Care (BMC), including, but not limited to: • a denial because the requested service or item is not a covered service; which does not include a Benefit Limit Exception (BLE). • the failure of the Plan to provide a service or item in a timely manner, as defined by the Department;

	• the failure of the Plan to decide a Complaint or Grievance within the specified time frames; • a denial of payment by the Plan after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program; • a denial of payment by the Plan after a service or item has been delivered because the service or item provided is not a covered service for the Member; or • a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities. This term does not include a Grievance.
Concurrent Review	A review conducted by the Plan during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.
County Assistance Office (CAO)	The county offices of the Department that administer all benefit programs, including MA, on the local level. Department staff in these offices performs necessary functions such as determining and maintaining recipient eligibility.
Cultural Humility	The ability of organizations, systems and health care professionals to respect and respond to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

Cultural Responsiveness	The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
Culturally and linguistically appropriate practices	Seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. (Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, OMH, 2013).
Denial of Services	Any determination made by the Plan in response to a request for approval, which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service, which includes a requirement for a Concurrent Review by the Plan during the authorized period, does not constitute a Denial of Service.
Denied Claim	An Adjudicated Claim that does not result in a payment obligation to a Provider.
Department	The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.
Developmental Disability	A severe, chronic disability of an individual that is: • Attributable to a mental or physical impairment or combination of mental or physical impairments. • Manifested before the individual attains age twenty-two (22). • Likely to continue indefinitely. • Manifested in substantial functional limitations in three or more of the following areas of life activity: o Self-care

	○ Receptive and expressive language ○ Learning ○ Mobility ○ Capacity for independent living and ○ Economic self-sufficiency Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in Developmental Disabilities if services are not provided.
Disease Management	An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.
Dispute (or Informal Provider Dispute)	A verbal or written expression of dissatisfaction by a Network Provider regarding a decision by the Plan that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning Medical Necessity. Disputes may focus on issues concerning the Plan services and processes, other Health Care Providers, Member, or claims (e.g. frequency of on-site visits, dissatisfaction with detail of Member information on panel list, Member non-compliance, timeliness of claims payments, etc.). Examples of Disputes include, but are not limited to: • Service issues with the Plan, including failure by the Plan to return a Provider's calls, frequency of site visits

	by the Plan's Provider Account Executives and/or lack of Provider Network orientation/education by the Plan. • Issues with the Plan processes, including failure to notify Network Providers of policy changes, dissatisfaction with the Plan's Prior Authorization process, dissatisfaction with the Plan referral process and dissatisfaction with the Plan's Provider Appeal process. Contracting issues, including dissatisfaction with the Plan's reimbursement rate, incorrect payments paid to the Network Provider and incorrect information regarding the Network Provider in the Plan's Provider database.
Dual Eligibles	An individual who is eligible to receive services through both Medicare and Medicaid. Dual Eligibles age twenty-one (21) and older, and who have Medicare, Part D, no longer participate in HealthChoices and will be disenrolled from HealthChoices prospectively.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).
Early Intervention Program	The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.
Eligibility Period	A period of time during which a consumer is eligible to receive MA benefits. An Eligibility Period is indicated by the eligibility start and

	end dates on eCIS. A blank eligibility end date signifies an open- ended Eligibility Period.
Eligibility Verification System (EVS)	An automated system available to MA Providers and other specified organizations for automated verification of MA Recipients'current and past (up to three hundred sixty-five [365] days) MA eligibility, Plan enrollment, PCP assignment, Third Party Resources, and scope of benefits.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions (or) • Serious dysfunction of any bodily organ or part
Emergency Services	Covered inpatient and outpatients services that: • Are furnished by a Provider that is qualified to furnish such service under Title XIX of the Social Security Act; and • Are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any covered health care service provided to a Member regardless of whether it has an associated Claim. A Claim form must be created and submitted to the Plan for all Encounters, whether reimbursed through Capitation, fee-for-service, or another method of compensation.
Enrollee	A Medicaid beneficiary who is currently enrolled in a Plan.
Enrollment	The process by which a Member's coverage by a Plan is initiated.
Expanded Services	Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42

	U.S.C. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to Members.
Experimental Treatment	A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.
Family Planning Services	Diagnosis, treatment, drugs, supplies, and related counseling which are provided to individuals of child-bearing age to enable the individuals to determine freely the number and spacing of their children.
Federally Qualified Health Center (FQHC)	An individual health center site location that is receiving, or meets all of the requirements to receive (FQHC "look alike"), grant funds under Section 330of the Public Health Services (PHS) Act; or that does not currently meet all of the FQHC requirements under the PHS Act, but does meet all applicable requirements for Medical Assistance (MA) providers as set forth in 55 Pa. Code Chapter 1101 of the MA regulations (including licensure and certification standards under Pennsylvania Law), and receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as a FQHC.

Formal Provider Appeals or Provider Appeal	A written request from a Health Care Provider for reversal of a determination by the Plan, with regard to two (2) major types of issues: (1) Disputes not resolved to the Network Provider's satisfaction through the Plan's Informal Provider Dispute process and (2) denials for services already rendered by the Health Care Provider to a Member including denials that: (a) do not clearly state the Health Care Provider is filing a Member Complaint or Grievance appeal on behalf of a Member (even if the materials submitted with the appeal contain a Member consent) or Examples of Provider Appeals include, but are not limited to: • Determinations of medical necessity through Concurrent Review, such as denials or downgrades for inpatient services; • Denials for services provided to Members without obtaining required Prior Authorization; • Claims payment issues not resolved to the Network Provider's satisfaction through the Informal Provider Dispute Process. • Other denials--including Retrospective Review--for services already rendered by the Health Care Provider to a Member. Appeals of Health Care Provider credentialing denials by the Plan and Health Care Provider terminations are addressed through separate appeal processes.
Formulary	A Department-approved list of Covered Drugs determined by the PH-MCO's P&T Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the PH-MCO Members.
Fraud	Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or

	person, or some other person in a managed care setting, committed by any entity, including the Plan, a subcontractor, a Provider, or a Member, among others.
Grievance	A request to the Plan by a member or a member's authorized representative to have the Plan reconsider a decision solely concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered service/item. If the Plan is unable to resolve the matter, a Grievance may be filed regarding the decision that: 1) disapproves full or partial payment for a requested health care service/item; 2) approves the provision of a requested health care service/item for a lesser scope or duration than requested; or 3) disapproves payment for the provision of a requested health care service/item but approves payment for the provision of an alternative health care service/item. The term does not include a Complaint.
Health Care Provider	A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth (or state(s) in which the entity or person provides services), including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, public health dental hygiene practitioner, pharmacist or an individual accredited or certified to provide behavioral health services.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A federal law (Public Law 104-191) and its accompanying regulations enacted to, among other things, improve the portability and continuity of health insurance, combat waste, fraud, and abuse in health insurance and health

	care delivery, and simplify the administration of health insurance through the development of standards for the electronic exchange of health care information and protecting the security and privacy of personally identifiable health information.
Health Maintenance Organization (HMO)	A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed, prepaid fee.
HealthChoices Program	The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Recipients.
Intellectual Disability	An impairment in intellectual functioning which is life-long and originates during the developmental period (birth to twenty-two (22) years). It results in substantial limitations in three or more of the following areas: learning, self-direction; self-care; expressive and/or receptive language; mobility; capacity for independent living; and economic self-sufficiency.
Intermediate Care Facility for the Intellectually Disabled and Other Related Conditions (ICF/MR/ORC)	An institution (or distinct part of an institution) that: 1) is primarily for the diagnosis, treatment or rehabilitation for persons with Intellectual Disabilities or persons with other related conditions; and 2) provides, in a residential setting, ongoing evaluation, planning, twenty-four (24) hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her maximum capacity.

Juvenile Detention Center (JDC)	A publicly or privately administered, secure residential facility for: • Children alleged to have committed delinquent acts who are awaiting a court hearing; • Children who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and • Children who have been returned from some other form of disposition and are awaiting a new disposition (i.e., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).
Managed Care Organization (MCO)	An entity that manages the purchase and provision of physical or behavioral health services under the HealthChoices Program.
Medical Assistance (MA)	The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §§1396 et seq.,and regulations promulgated there under, and 62 P.S. §§441.1 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq.
Medical Assistance Transportation Program (MATP)	A non-emergency medical transportation service provided to eligible persons who need to make trips to and from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.
Medically Necessary	A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that: • Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability. • Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability. • Will assist 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.
Member	An individual who is enrolled with the Plan under the HealthChoices Program and for whom the Plan has agreed to arrange the provision of physical health services under the provisions of the HealthChoices Program.
National Provider Identifier (NPI)	A unique identifier for every Health Care Provider on a national level. NPI's replace Provider Identification Numbers (PINs) assigned by Medicare, Medicaid and local carriers. NPI's will replace Provider Unique Physician/practitioner Numbers (UPINs). It is not a replacement of or substitution for Tax Identification or Drug Enforcement Administration (DEA) numbers.
Network	All contracted or employed Providers in the Plan who are providing covered services to Members.
Network Provider	An MA enrolled Provider that has a written Network Provider Agreement, and participates in the Plan's Network to serve the Plan's Members.
Non-Participating Provider	A Health Care Provider, whether a person, firm, corporation, or other entity, either not enrolled in the Pennsylvania MA Program or not participating in the Plan's Network, which provides medical services or supplies to the Plan's Members.
Nursing Facility	A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MA Program and certified for Medicare participation. The provider types and specialty codes are as follows: • General - PT 03, SC 030 • County - PT 03, SC 031 • Hospital-based - PT 03, SC 382 • Certified Rehab Agency – PT 03, SC 040
Observation Care	Observation Care is a clinically appropriate Utilization Management designation for patient services, which include ongoing short term treatment, assessment, and reassessment,

	before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the Observation Care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient Observation services span more than 48 hours.
Out-of-Plan Services	Services that are non-plan, non-capitated and are not the responsibility of the Plan under the HealthChoices Program comprehensive benefit package.
Physical Health Managed Care Organization (PH-MCO)	A risk-bearing entity which has an agreement with the Department to manage the purchase and provision of Physical Health Services under the HealthChoices Program.
Post-Stabilization Services	Medically Necessary non-Emergency Services furnished to a Member after the Member is stabilized following an Emergency Medical Condition.
Primary Care Case Management (PCCM)	A program under which the Department contracts directly with PCPs who agree to be responsible for the provision and/or coordination of medical services to MA recipients under their care.
Primary Care Provider (PCP)	A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services;

	and maintaining continuity of care on behalf of a Recipient.
Prior Authorization	A determination made by the Plan to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested services.
PROMISe™ Provider Identification Number (PPID Number)	A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.
Provider	An individual or entity that is engaged in the delivery of medical or professional services, or ordering or referring for those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, , pharmacist, and an individual accredited or certified to provide behavioral health services.
Provider Agreement	Any Department approved written agreement between the Plan and a Provider to provide medical or professional services to the Members to fulfill the requirements of this Agreement.
Quality Assessment and Performance Improvement	An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.
Retrospective Review	A review conducted by the Plan, DHS, or DHS vendor or designee to determine whether services were delivered as prescribed and consistent with the Plan's payment policies and procedures in accordance with MA regulations and the DHS Agreement.

Sanction	An adverse action taken against a physician or allied health professional's participating status with the Plan for a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community.
Short Procedure Unit (SPU)	A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic or medical services.
Special Healthcare Needs	The individualized care that a person, especially children, requires due to a physical, developmental, or mental condition that necessitates medical intervention, specialized services, or accommodations beyond what's typically needed.
Subcontract	A contract between the Plan and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the Plan's responsibilities under this Agreement.
Third Party Liability (TPL)	An individual entity or program's (e.g. Medicare) other than the Plan's financial responsibility for all or part of a Member's health care expenses.
Title XVIII (Medicare)	A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. §§1395 et seq., covering almost all Americans sixty- five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.
Transitional Care Home	A tertiary care center that provides medical and personal care services to children upon discharge from the hospital that require intensive medical care for an extended period of time. This transition allows for the caregiver to be trained in the care of the child, so that the child can eventually be placed in the caregiver's home.
United States	As used in the context of payment for services or items provided outside of the United States, the term "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands

	and American Samoa. The definition shall be updated from time to time to remain consistent with the Social Security Act.
Urgent Medical Condition	Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The terms also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.
Utilization Management	An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost- effective manner.
Vaccine For Children (VFC)	The Pennsylvania Department of Health's Vaccines for Children Program provides vaccines to children who are Medicaid eligible or do not have health insurance and to children who are insured but whose insurance does not cover immunizations (underinsured). These vaccines are to be given to eligible children without cost to the Provider or to the Member. All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program.
Waste	The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Section 1: Covered Benefits

Covered Benefits

AmeriHealth Caritas Pennsylvania (hereafter referred as **"the Plan"**) Members are entitled to all of the benefits provided under the Pennsylvania Medical Assistance Program.

Depending on the Member's category of aid and age, benefit limits and co-payments may apply. Please refer to the Member Copayment schedule that follows this section. The most current version of the Member Copayment schedule can be found online at www.amerihealthcaritaspa.com → Providers → Billing → Member copay schedule.

Benefits include, but are not necessarily limited to, the following:

- Ambulance
- Behavioral Health Services*
- Chemotherapy and Radiation Therapy
- Dental Care
- Durable Medical Equipment and Medical Supplies
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- Family Planning
- Home Health Care
- Hospitalization
- Laboratory Services
- Nursing Facility Services
- Obstetrical/Gynecological Services
- Other specialty care services**
- Pharmacy Services
- Physical, Occupational, and Speech Therapy
- Primary Care Services
- Rehabilitation Services
- Renal Dialysis
- Vision Care

* Please note! Under the HealthChoices Program, behavioral health services are coordinated through, and provided by, the Member's county Behavioral Health Managed Care Organization (BH-MCO). These services are not part of the Plan's benefit package, but are available to all Plan Members through the BH- MCO.

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

IMPORTANT NOTE:

AmeriHealth Caritas Pennsylvania is required to comply with requirements by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) that all providers, including those who order, refer or prescribe items or services for AmeriHealth Caritas Pennsylvania members, must be enrolled in the Pennsylvania Medical

Assistance (MA) Program. The complete DHS MA bulletin (99-17-02 and 99-18-06) outlining all requirements can be accessed on both websites here:

www.amerihealthcaritaspa.com → Provider → Communications → DHS/Medical Assistance Bulletins.

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

Services Not Covered

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

- Services that are not Medically Necessary
- Services rendered by a Health Care Provider who does not participate with the Plan, except for:
    - Medicare-covered services (see note at the end of the section titled Prior Authorization Requirements in Section 2);
    - Emergency Services;
    - Family Planning Services; or
    - When otherwise prior authorized by the Plan.
- Cosmetic surgery, such as tummy tucks, nose jobs, face lifts and liposuction.
- Dental Implants and associated procedures.
- Experimental Treatment and investigational procedures, services and/or drugs.
- Infertility Services.
- Paternity Testing.
- Any service offered and covered through another insurance program, such as Worker's Compensation, TRICARE or other commercial insurance that has not been prior authorized by the Plan. However, Medicare covered services provided by a Medicare provider do not require Prior Authorization.
- Motorized Lifts for Vehicles.
- Services provided outside the United States and its territories. The Plan is prohibited from making payments for services provided outside of the United States and its territories.
- Private duty (also known as shift care) skilled nursing and/or private duty home health aide services for Members 21 years of age or older.
- Services not considered a "medical service" under Title XIX of the Social Security Act.
- Structural or Home Modifications including:
    - Modifications to the home or place of residence;
    - Repairs of the home, including repairs caused by the installation, use, or removal of the medical equipment or appliance; and
        - Changes to the internal or external infrastructure of the home or residence including:
        - Adding internal supports such that the support requires access to the area behind a wall or ceiling or underneath the floor;
        - Constructing retaining walls or footers for a retaining wall;

- Installation of or modification of a deck;
- Installation of a driveway or sidewalk;
- Upgrading the electrical system;
- Plumbing;
- Ventilation or HVAC work;
- Widening a doorway;
- Drywall;
- Painting;
- Installation of flooring or carpeting;
- Tile work;
- Landscaping: and
- Demolition of existing property or structure

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

Member Co-Payment Schedule

Member co-payment schedules may be found on our websites at **www.amerihealthcaritaspa.com** **Providers → Billing → Member copay schedule**.

Important note: Members do not have any copays for naloxone.
The Plan has a dedicated Opioid Treatment resource web pages that provide information and resources including state, local and Plan resources. Visit the site at:
http://www.amerihealthcaritaspa.com/pharmacy/index.aspx

Section 2: Referral and Authorization Requirements

Referral Requirements

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

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

AmeriHealth Caritas Pennsylvania is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) that require all providers, including those who order, refer or prescribe items or services for AmeriHealth Caritas Pennsylvania members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02 and 99-18-06) outlining all requirements can be accessed on the websites at **www.amerihealthcaritaspa.com** → **Providers** → **Communications** → **DHS and Medical Assistance Bulletins**.

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

Resources – DHS offers a Medical Assistance Enrolled Provider Lookup Function

The DHS lookup function allows enrolled providers to verify that their colleagues who are ordering, prescribing or referring services are enrolled in the Pennsylvania MA program. Access the lookup function at the following link:

https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

Services Requiring a Referral:

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

Services Not Requiring a Referral (Member Self-Referral):

- Prenatal OB visits
- Routine OB/GYN visits
- Routine Family Planning Services. Members may go to any doctor or clinic of their choice to obtain Family Planning Services.
- Routine Eye Exams **

- Prescription eyeglasses for Members under 21 years of age
- Routine Dental Services ***
- Initial Chiropractic Visit/Evaluation
- The following Diagnostic Tests performed on an outpatient basis with a prescription: Routine Mammograms, Chest X-rays, Ultrasounds, Non-Stress Tests, Pulmonary Function Tests (Please refer to the Prior Authorization list in this section of the Manual for a list of radiological procedures that require Prior Authorization)
- Pre-Admission Testing and Stat Lab Services
- Diagnostic Tests and Procedures performed in a Short Procedure Unit, Ambulatory Surgery Center or Operating Room****
- Routine lab work
- Tobacco Cessation Counseling
- Emergency Services including emergency transportation
- DME Purchases less than $750 if on MA Fee Schedule and with a prescription
- Behavioral Health, Substance Use Disorder treatment (Refer to the Behavioral Health Section.)

*For Members with a life-threatening, degenerative or disabling disease or condition, or Members with other Special Healthcare Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at **1-800-521-6007** (AmeriHealth Caritas Pennsylvania)
Some Specialty Eye Care Services may require a referral. See **"Ophthalmology Services" in this Section in the Manual.
***Some Dental Services may require Prior Authorization and/or Benefit Limit Exception. See **"Dental Services"** in this section of the Manual.
****A referral is not necessary but Prior Authorization is required for the following:

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

Referral Process

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

The PCP's office should:

- Verify Member eligibility by using one of the verification methods in Section 3: Member Eligibility

- Determine if the needed service requires a referral or Prior Authorization from the Plan (See "Services Requiring Referrals and Prior Authorization" in this section of the Manual)
- Select a participating Specialist/ hospital or other outpatient facility appropriate for the Member's medical needs from the Specialist Directory, as appropriate. There is also an online Network Provider Directory with search capability at **www.amerihealthcaritaspa.com** (If an appropriate Network Provider is not listed in the Network Provider Directory please call Provider Services at **1-800-521-6007).**

See **"Out-of-Plan Referrals"** in this Section for additional information.

How to refer a Member to a Plan participating specialist:

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

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

The Specialist office should:

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

Approval of Additional Procedures

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

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

If the procedure/treatment does require Prior Authorization, **submit via Navinet Provider Portal Medical Authorizations** at **www.navinet.net** for Prior Authorization. It is not necessary that the Specialist or Member re-contact the PCP office, however, the Specialist's office should inform the PCP of all diagnostic procedures, diagnostic tests and follow-up care prescribed for the Member.

Providers also have the option to submit a paper Prior Authorization form via fax. The Prior Authorization form can ber found on our website at **www.amerihealthcaritaspa.com** → **Providers → Resources → Forms**.

Additional Procedures Requiring Inpatient or SPU Admission

When the Specialist determines that additional medical or surgical procedures require an inpatient or SPU admission, the Specialist must first determine if the procedures require further Prior Authorization. See "Prior Authorization Requirements" in this section of the Manual. When a procedure does require Prior Authorization, the Specialist should **submit via Navinet Provider Portal Medical Authorizations at www.navinet.net** to obtain Prior Authorization. The admission will be reviewed for medical necessity and a case reference number will be assigned. Pre-approval for medical/surgical admissions may be requested directly by the attending specialist. It is not necessary that the Primary Care Provider (PCP) be contacted first, however, the Plan requires Specialists to maintain contact with the referring PCP regarding the Member's status.

Specialists should provide timely communication back to the member's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care.

Follow-Up Specialty Office Visits

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

The Specialist office should:

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

When the Specialist requires that the Member be referred to another Specialist, either for evaluation and management or a diagnostic or treatment procedure, this visit must be approved by the Member's PCP. Either the Specialist's office or the Member should advise the PCP office of the need for the follow up services. The PCP office should then follow the referral process. See "**Referral Process**" in this section of the Manual.

Out-of-Plan Referrals

Occasionally, a Member's needs cannot be provided through the Plan's Network. When the need for "out-of-plan" services arises, the Network Provider should contact the Utilization Management Department. The Utilization Management Department will make arrangements for the Member to receive the necessary medical services with a Specialist of the Plan's choice in collaboration with the recommendations of the PCP. Every effort will be made to locate a Specialist within easy access to the Member. Please call the AmeriHealth Caritas Pennsylvania Utilization Management Department at **1-800-521-6622**.

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

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

Enroll by visiting:
https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx

Standing Referrals

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

Referrals/Second Opinions

Second opinions, or consultations, may be requested by a Member, the PCP, or the Plan itself. These services require a referral from the PCP. For more information, see the "Referral Process" in this section of this Manual for direction.

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

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

Prior Authorization Requirements

The most up to date listing of services requiring Prior Authorization can be found in the Provider Center at **www.amerihealthcaritaspa.com** under Prior Authorization or in posted updates. Providers can also verify if a specific code or service requires authorization by using the Prior Authorization Look Up Tool at **www.amerihealthcaritaspa.com** → **Providers** → **Prior Authorization** → **Prior authorization lookup tool**.

For Prior Authorization request including Program Exceptions please note the below Prior Authorization Tips:

1. Please use the AmeriHealth Caritas Pennsylvania Prior Authorization form and clearly indicate what device/ service you are requesting and the date of service. Fill out the form as completely as possible (including treating and referring doctors).
2. Send clinical information that is directly related to the device or service that you are requesting.
3. Avoid handwritten forms which, when faxed, can be misunderstood or difficult to read.
4. In addition, please use a fax cover sheet stating what you want specifically.

Prior Authorizations should be faxed to the outlined telephone numbers listed on the Prior Authorization Form. The form can be found on our website at **www.amerihealthcaritaspa.com** → **Providers** → **Resources** → **Prior Authorization**. Reimbursement for all rendering providers for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medicaid Provider ID. Claims submitted by rendering providers will be denied if the ordering, referring or prescribing provider is not enrolled in the Pennsylvania Medical Assistance program.

To check the MA enrollment status of the practitioner ordering, referring or prescribing the service you are providing, visit the DHS provider look-up portal at:

https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

Prior Authorization Lookup tool

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

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

To access the Prior Authorization Lookup tool, visit: **www.amerihealthcaritaspa.com** → **Providers → Prior authorization lookup tool**.

Services that require prior authorization*:

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

- All elective (scheduled) inpatient hospital admissions medical and surgical including rehabilitation.
- All elective transplant evaluations and procedures.
- Elective/non-emergent air ambulance transportation.
- All elective transfers for inpatient and/or outpatient services.
- Skilled nursing facility admission for alternate levels of care in a facility, either free-standing or part of a hospital, that accepts patients in need of skilled-level rehabilitation and/or medical care that is of a lesser intensity than that received in a hospital, not to include long-term care placements.
- Select gastroenterology services
- Bariatric surgery.
- Pain management services performed in a short procedure unit (SPU) or ambulatory surgery unit (either hospital-based or free-standing) and pain management services not on the Medical Assistance fee schedule performed in a physician's office require prior authorization
- Cosmetic procedures regardless of treatment setting including but not limited to the following: reduction mammoplasty, gastroplasty, ligation and stripping of veins, and rhinoplasty.
- Outpatient therapy services (physical, occupational, speech and aquatic)
    - Prior authorization is not required for an evaluation and up to 24 visits per discipline within a calendar year.
    - Prior authorization is required for services exceeding 24 visits per discipline within a calendar year.
- Cardiac or pulmonary rehabilitation.
- Chiropractic Services:
    - Chiropractic services after the 24th visit if the member is under the age of 18.

- Home health services performed by a network provider.
    - Prior authorization is not required for up to 18 visits per modality per calendar year including: skilled nursing visits by an R.N. or L.P.N.; home health aide visits; physical therapy; occupational therapy; and speech therapy; Home Respiratory Therapy; Mechanical Ventilation Care; Stoma Care and Maintenance, including Colostomy and Cystectomy and services of Clinical Social Workers in home health or hospice settings
    - The duration of services may not exceed a 60-day period. The member must be reevaluated every 60 days.
    - All shift care/private duty nursing services require prior authorization including services performed at a medical daycare or prescribed pediatric extended care center (PPECC).
    - Injectables.
    - Home sleep study.
- Durable medical equipment (DME):
    - DME rentals and purchases of items in excess of $750.
    - The purchase of all wheelchairs (motorized and manual) and all wheelchair items (components) regardless of cost per item.
    - Select Prosthetic and Orthotic items*
- Home Accessibility DME Equipment (refer to the DME section of the manual for complete details)
- Enterals:
    - Select Enterals and Paraenterals*
- Diapers/Pull-ups:
    - Any request in excess of 300 diapers or pull-ups per month or a combination of both requires prior authorization. Any request in excess of 300 diapers or pull-ups or a combination of both will be reviewed for medical necessity.
    - Requests for brand-specific diapers require prior authorization.
    - Requests for diapers supplied by any DME provider other than J&B Medical Supply require prior authorization. Refer to the DME section of the Provider Manual for complete details.
- Home Oxygen Therapy
    - All requests for oxygen and oxygen equipment require authorization. Initial authorization is for 6 months and reauthorizations require an updated prescription with current oxygen saturation level (refer to the Durable Medical Equipment section for complete requirements and details).
- Select radiological exams — **excludes** radiological studies that occur during inpatient, emergency room, and/or observation stays.
    - Positron emission tomography (PET).
    - Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA).
    - Nuclear cardiology diagnostic testing.
    - Computed axial tomography (CT/CAT scans) and CT angiography.

        - Prior authorization for these radiological exams is obtained by Evolent Specialty Services, Inc. (Evolent) at **www.radmd.com** or calling:
            - **1-800-424-5657** for AmeriHealth Caritas Pennsylvania members.
- Any service(s) performed by nonparticipating or non-contracted practitioners or providers, unless the service is an emergency service.
- All services that may be considered experimental and/or investigational.
- Neurological psychological testing.
- Genetic laboratory testing.
- All miscellaneous/unlisted or not otherwise specified codes.
- Program Exception Process: Any service/product not listed on the Medical Assistance fee schedule or services or equipment in excess of limitations set forth by the Department of Human Services fee schedule, benefit limits, and regulation. (Regardless of cost, i.e., above or below the $750 DME threshold).
- Ambulance Transportation to and from Prescribed Pediatric Extended Care Center (PPECC)/Medical Daycares Guidelines
    - Member is under 21 years of age.
    - Member is approved for services at a PPECC/medical daycare.
    - Member requires intermittent or continuous oxygen, ventilator support, and/or critical physiologic monitoring or critical medication(s) during transport requiring ambulance level of care.
    - There are no existing mechanisms for caregivers to transport the member.
    - Requests for ambulance services are prior authorized along with initial request for PPECC/medical daycare services, with each reauthorization of medical daycare services, and/or when there is a change in level of care regarding oxygen, ventilator support, and/or specific medical treatment during transport.
    - Rapid Response Transportation Department will be notified with each ambulance approval to initiate and/or continue ambulance transport services.
- Select medications. For information on which medications require authorization, see the Plan's Formulary at **www.amerihealthcaritaspa.com** → **Pharmacy** → **Formulary** → **Searchable Formulary**.
- Select dental services. For information on which dental services require prior authorization, please refer to the Dental Services section of the Provider Manual.
- Elective termination of pregnancy – Refer to the Termination of Pregnancy section of the Provider Manual for complete details.

*Authorization policies are subject to change. Please use the Prior Authorization Lookup tool to verify if a specific code or service requires authorization at **www.amerihealthcaritaspa.com** → **Providers** → **Prior authorization** → **Prior authorization lookup tool**.

Prior Authorization through NaviNet

Prior Authorization Submission through Medical Authorizations via the Navinet Provider Portal. For detailed information, Frequently Asked Questions and training materials, visit AmeriHealth Caritas Pennsylvania Medical Assistance Plan Central on www.navinet.net.

- **Access Medical Authorizations, a streamlined online authorization workflow:**
  - Submit an Authorization
  - Submit an amended authorization
  - Verify if no authorization is required
  - Inquire on existing authorization
  - Attach supplemental documentation
  - Sign up for in-app status change notifications directly from the health plan
  - Access an authorization log
  - Medical Authorizations Video tutorials and user guide are available on the Navinet Plan Central Home Page

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

The following information is required in order to properly assess a provider's request for prior authorization: member's plan ID number, member's name, member's date of birth, diagnosis/ses (ICD-10), requested CPT codes, date of service, ordering/referring doctor's NPI, facility/treating providers NPI, applicable clinical information.

Reimbursement for all rendering providers for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medicaid Provider ID. Claims submitted by rendering providers will be denied if the ordering, referring or prescribing provider is not enrolled in the Pennsylvania Medical Assistance program.

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

https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

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

Any additional questions regarding prior authorization requests may be addressed by calling AmeriHealth Caritas Pennsylvania Utilization Management/Prior Authorization at **1-800-521-6622.**

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

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

Policies and Procedures

Medically Necessary

A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist 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.

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

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

Benefit Limits and Co-Payments

There may be benefit limits or co-payments* associated with the services mentioned in this section. Please refer to the Member Copayment Schedule on the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com.**

*Network Providers and other Providers may not deny a covered service because a Member is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

Authorization and Eligibility

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 1st of each month when a Prior Authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the Provider must call the Plan's Utilization Management Department to obtain Prior Authorization for continuation of service.

Department of Human Services Medical Assistance Program Services

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

The Medical Assistance Program Services line is answered by nurses who work for DHS. If a Health Care Provider or Member requests medical care or services, and the Plan or the BH-MCO has not responded in time to meet the Health Care Provider or Member's needs, call the Service. A Health Care Provider or Member can call the Medical Assistance Program Services if the Plan or the BH-MCO has denied Medically Necessary care or services or will not accept a request to file a Grievance, or if they are having trouble getting shift home health services that have been authorized by the Plan.

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

Ambulance

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

Members may access non-ambulance non-emergency medical transportation and behavioral health appointments through the Medical Assistance Transportation Program (MATP); however, the Plan is not financially responsible for payment for these services. Members should be advised to contact the BH-MCO in their county of residence for assistance in accessing non-ambulance non-emergency medical transportation for behavioral health appointments that are not covered by MATP.

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

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

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

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

Behavioral Health Services

Behavioral Health Services, including all mental health and substance use disorder services are provided by county-specific behavioral health plans. Go here for more information: **https://www.enrollnow.net/program-resources** (behavioral health entities also listed in the Important Contact Numbers section of this manual).

Members may self-refer for behavioral health services. However, PCPs and other physical healthcare providers often need to recommend that a Member access behavioral health services. The Health Care Provider or his/her staff can obtain assistance for Members needing behavioral health services by calling the toll free number noted in the Important Contact Numbers section of this manual.

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

- Adhere to state and Federal confidentiality guidelines for Member medical records, including obtaining any required written Member consents to disclose confidential mental health and substance use disorder treatment records.
- Refer Members to the appropriate BH-MCO, once a mental health or substance use problem is suspected or diagnosed.

- To the extent permitted by law, participate in the appropriate sharing of necessary clinical information with the Behavioral Health Provider including, if requested, all prescriptions the Member is taking.
- Be available to the Behavioral Health Provider on a timely basis for consultation.
- Participate in the coordination of care when appropriate.
- Make referrals for social, vocational, educational and human services when a need is identified through an assessment.
- Refer to the Behavioral Health Provider when it is necessary to prescribe a behavioral health medication, so that the Member may receive appropriate support and services necessary to effectively treat the problem.

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

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient substance use disorder treatment(withdrawal management and residential treatment)
- EPSDT behavioral health rehabilitation services for Members up to age 21

Centers of Excellence (COEs) help ensure that people with opioid-related substance use disorder (SUD) stay in treatment to receive follow-up care. A COE provides community support. The centers coordinate care for people with Medicaid. The treatment is team-based and "whole person" focused, with the explicit goal of integrating behavioral health and primary care.

For behavioral health and substance use disorder resources, including information about Centers of Excellence and resources for pregnant members with substance use disorders, please refer to our websites at **www.amerihealthcaritaspa.com → Providers → Resources**

The Plan has dedicated Opioid Treatment resource web pages that provide information and resources including state, local and plan resources. Visit the site at:
www.amerihealthcaritaspa.com → Pharmacy → Opiod treatment resources

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

Health Care Providers may call AmeriHealth Caritas Pennsylvania Provider Services Department at **1-800-521-6007** whenever they need help referring a Member for behavioral health services.

Dental Services

Members do not need a referral from their PCP, and can choose to receive dental care from any provider who is part of the dental network. Member inquiries regarding covered dental services should be directed to AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-**

991-7200. All Members have dental benefits. Providers with inquiries regarding covered dental services should call Dental Provider Services at **1-855-343-7401.** Provider Services staff are available Monday-Friday 8:00A.M. – 6:00 P.M.

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

Dental Benefits for Children under the age of 21

Children under the age of 21 are eligible to receive all Medically Necessary dental services. Children may go to any dentist that is part of the Plan's network. Participating dentists can be found in our online provider directory at **www.amerihealthcaritaspa.com** or by calling AmeriHealth Caritas Pennsylvania Member Services at **1-888-991-7200.**

Dental services that are covered for children under the age of 21 include the following, when Medically Necessary:

- Anesthesia***
- Orthodontics*and***
- Check-ups
- Periodontal services***
- Cleanings
- Fluoride Treatments (topical fluoride varnish can also be done by a PCP,CRNP, or Physicians Assistants)**
- Silver Diamine Fluoride
- Endodontics (including Root Canals)***
- Crowns***
- Sealants
- Dentures***
- Dental surgical procedures***
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

**If braces were put on before the age of 21, the Plan will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains eligible for Medical Assistance and is still a Member of the Plan. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the member loses eligibility, the Plan will pay for services through the month that the member is eligible. If a member loses eligibility during the course of treatment, you may charge the member for the remaining term of the treatment after the Plan's payments cease ONLY IF you obtained a written, signed agreement from the member*

prior to the onset of treatment. For case specific clarification, please contact the AmeriHealth Caritas Pennsylvania Dental Account Executive.

** Participating PCPs, CRNPs and Physicians Assistants with appropriate training and certification may administer and bill for fluoride varnish treatments for children less than twenty-one (21) years old up to a maximum of six (6) times per year. Fluoride varnish is defined as a service that may be provided by a participating PCP or CRNP during which each tooth of a child (less than 21 years old) is painted with a fluoride solution under a specific application protocol.

Providers are expected to take the on-line "Caries Risk Assessment, Fluoride Varnish & Counseling" educational course before administering fluoride varnish to assigned members less than five (5) years old. The link to the training module is available in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com → Providers → Resources →Provider training and education → Primary care fluoride varnish training module**

PCPs are expected to refer each child receiving a fluoride varnish to a pediatric or general dentist for follow-up care. Provision of this dental-related preventive service by the PCP to young children is designed as a gateway to regular dental care, and is not conceived or intended to be provided regularly, year-after-year, for the same child, in the absence of a dental home.

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

Dental Benefits for Members age 21 and older

The following dental services are covered for Members with dental benefits who are age 21 and older:

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

* Authorization is required and medical necessity must be demonstrated.
** Benefit Limit Exceptions may apply.

The Plan's dental benefits for Members age 21 and older include:

- 1 dental exam and 1 cleaning per member every 180 days. (Benefit Limit Exceptions may apply if services are requested more frequently than every 180 days)

- Re-cementing of crowns.
- Pulpotomies to provide symptomatic relief of dental pain.
- Dentures: one removable prosthesis per member, per arch, regardless of type (full/partial), per lifetime.
    - If the member received a partial or full upper or lower denture since April 27, 2015, paid for by the Plan, other MCOs, or the state's fee-for-service plan, they must request and be approved for a benefit limit exception to get another partial or, full upper or lower denture.

Benefit Limit Exception Process

Members age 21 and over may be eligible to receive crowns and adjunctive services, root canals, additional dentures, additional cleanings and exams, other endodontic services and periodontal services through the benefit limit exception process. The Plan participating dentists should call Dental Provider Services at **1-855-343-7401**to request a benefit limit exception form. The form can also be downloaded at **www.amerihealthcaritaspa.com → Providers → Resources → Dental program → Dental benefit limit exception form**. **https://www.amerihealthcaritaspa.com/pdf/provider/resources/forms/dental-ble-form.pdf .** Refer to the Dental Provider Supplement Manual for detailed information about the Benefit Limit Exception Process.

The Plan may grant benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member; or
- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the Member; or
- Granting a specific exception is a cost effective alternative for the Plan; or
- Granting an exception is necessary in order to comply with federal law.

For any questions on eligibility or dental benefits, please contact the Dental Provider Service Department at **1-855-343-7401.**

Durable Medical Equipment

Covered Services

The Plan's Members are eligible to receive Medically Necessary durable medical equipment (DME) needed for home use. The prior authorization look-up tool can be used to confirm authorization requirements for specific DME items.

All DME purchases and monthly rentals in excess of $750 require authorization.

All wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or Member age must be Prior Authorized.

Home Accessibility DME Equipment

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

Covered items include:

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

Also covered are:

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

In addition, certain conditions apply to the following supplies:

Enteral Nutritional Supplements:

- Select Enterals and Paraenterals require authorization.Use the prior authorization lookup tool to verify if a specific code requires prior authorization.
- All requests for Enteral Nutritional Supplements for Members under the age of 5 must be checked for WIC eligibility by the provider prior to the request.

Diapers/pull-up diapers:

The Plan has partnered with J&B Medical Supply to supply incontinence supplies to Members.

- J&B Medical Supply will deliver incontinence supplies directly to a Member's home through a drop ship program.
- Prior Authorization is not required when ordering through J&B Medical Supply (**1-800-737-0045**). Diapers/pull-up diapers in excess of 300 require prior authorization.
- In order for a Member to obtain incontinence supplies through J&B Medical Supply, Providers must complete a J&B Medical Supply Diaper and Incontinence Supply Form (see Appendix for a sample form).
- Requests for diapers/pull-up diapers supplied by any other DME Network Provider requires Prior Authorization.

Prior authorization is required for diaper/pull-up diapers if:

- Members 3 years of age and over are requesting to have:
    - More than 300 generic diapers and/or pull-up diapers per month.
    - Brand-specific diapers.
    - Diapers supplied by a provider other than those listed above.

Home Oxygen Therapy

All requests for oxygen and oxygen equipment require authorization. Initial authorizations are for 6 months. Reauthorization requires an updated prescription with current oxygen saturation levels.

Requests for home oxygen therapy should be accompanied by a current signed prescription and a letter of medical necessity from the treating provider that includes:

- Diagnosis
- Documented oxygen saturation levels within the past twelve months
- How many liters per minute the Member is to be using
- Will the use be continuous, nocturnally, or as needed.

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

Occasionally, Members require equipment or supplies that are not traditionally included in the Medical Assistance Program. The Plan will reimburse participating DME Network Providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies not covered by the Medical Assistance Program but covered under Title XIX of the Social Security Act, provided that the equipment or service is Medically Necessary and the Network Provider has received prior approval from the Plan. In order to receive Prior Authorization, the requesting Network Provider can fax a letter of medical necessity to the Plan at **1-866-755-9841.**

The letter of medical necessity must contain the following information:

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

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

Elective Admissions and Elective Short Procedures

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

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

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

NOTE:

Behavioral health admissions must be coordinated with the appropriate BH-MCO**. Refer to the Important Telephone Numbers section of the manual for the county-specific contact numbers.**

Emergency Admissions, Surgical Procedures and Observation Stays

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

An appropriate level of care, for an admission from the ER, may be any one of the following:

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

Emergency Medical Services

ER Medical Care

ER Medical Care is defined as an admission to the Emergency Department for an Emergency Medical Condition where short-term medical care and monitoring are necessary.

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

All Providers, particularly emergency, critical care and urgent care providers, must be alert for the signs of suspected child abuse, and as mandatory reporters under the Child Protective Services law, know their legal responsibility to report such suspicions. To make a report call:

- ChildLine – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

A mandated reporter making an oral report of suspected child abuse to the department via the Statewide toll-free telephone number (**1-800-932-0313**) must also make a written report, which may be submitted electronically within 48 hours to the department or county agency assigned to the case by using the CY-47 Report of Suspected Child Abuse form, found here: **http://www.keepkidssafe.pa.gov/resources/forms/**

Additional resources addressing mandatory reporter requirements:

- The Juvenile Law Center of Philadelphia, Child Abuse and the Law: **http://www.jlc.org/resources/publications/child-abuse-and-law**
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**
- The Plan's dedicated web page to child abuse prevention on the provider center at **www.amerihealthcaritaspa.com**

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

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

Abuse or neglect of Plan member s age of 18-59 may be reported to Adult Protective Services by calling **1-800-490-8505**.

Additional resources may be found here:

https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Adult-Protective-Services.aspx

Emergency Room Policy

An "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Prior Authorization/Notification for ER Services/Payment:

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

PCP Contact Prior to ER Visit

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

Authorization of Inpatient Admission Following ER Medical Care

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

Emergency SPU Services

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

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

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

Authorization of Emergency SPU Services

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

Authorization of Inpatient Admission Following Emergency SPU Services

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

Emergent Observation Stay Services

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

Observation Care can be broken down into two categories:

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

Maternity/Obstetrical Observation Stay

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

- Symptoms of premature labor
- Abdominal pain
- Abdominal trauma
- Vaginal bleeding
- Diminished or absent fetal movement
- Premature rupture of membranes (PROM)

- Pregnancy induced hypertension/Preeclampsia
- Hyperemesis
- Gestational Diabetes

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

ER Medical Care rendered to a pregnant Member that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation. See "Claims Filing Instructions" in the appendix of the Manual for Claim submission procedures.

Authorization of Inpatient Admission Following OB Observation

If a Member is admitted as an inpatient following observation, the Facility is required to notify the Utilization Management Department and a case reference number will be issued based on member eligibility. Notification can be given via **Phone: 1-800-521-6622 or Fax: 1-855-332-0991** or electronically through Medical Authorizations NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet.

If the hospital does not have an L&D Unit, the hospital ER staff must include in their medical screening a determination of the appropriateness of treating the Member at the hospital versus the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For Members who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest AmeriHealth Caritas Pennsylvania participating hospital. Hospitals where members are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a weekend, the hospital staff should facilitate the transfer and notify AmeriHealth Caritas Pennsylvania Patient Care Management Department via a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and Member eligibility. All ER and Observation care charges are to be included on the inpatient billing form. Reimbursement will be at the authorized inpatient rate with no separate payment for the Emergency and/or Observation stay services. The inpatient case reference number should be noted on all Claims related to the inpatient stay.

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

Medical Observation Stay

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

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

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

Authorization of Inpatient Admission Following Medical Observation

If a Member is admitted as an inpatient following a Medical Observation Stay, notification is required to AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622** for authorization or electronically through Medical Authorizations NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet, Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the Member as an inpatient versus retention in the Observation Care setting of the facility. If the Member is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all Claims related to the inpatient stay.

Emergency Inpatient Admissions

Emergency Admissions from the ER, SPU or Observation Area

If a Member is admitted after being treated in an Observation, SPU or ER setting of the hospital, the hospital is responsible for notifying AmeriHealth Caritas Pennsylvania's Utilization Management

Department at **1-800-521-6622** within twenty-four (24) hours or by the next business day (whichever is later) following the date of service (admission). Notification can be given either by phone (above) or fax AmeriHealth Caritas Pennsylvania Admission Notification to **1-855-332-0991** utilizing the **Hospital Notification of Emergency Admissions form** (see the Appendix of the Manual for a copy of the form; the form can also be found in the Provider Forms section on **www.amerihealthcaritaspa.com**, or electronically through Medical Authorizations NaviNet Provider Portal. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. JIVA is the Plan's Member management information system. The Observation, SPU or ER charges should be included on the inpatient billing.

Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the Observation, SPU or ER services. The inpatient case reference number should be noted on the bill.

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

Utilization Management Inpatient Stay Monitoring

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

As a condition of participation in the Plan's Network, Providers must agree to the Utilization Management Department Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days, according to established criteria, under the direction of the Plan's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the Plan must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care. **The Plan must receive all clinical information on the inpatient stay every 5 days* which allows for decision and appropriate management of care.**

***Unless contract language indicates otherwise.**

Emergency Services Provided by Non-Participating Providers

The Plan will reimburse Health Care Providers who are not enrolled with the Plan when they provide Emergency Services for our Members.*

However, to comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), all providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This does not apply to non-participating out-of-state Providers under single case agreements.

DHS may make a determination that adopts the encounter limits or thresholds that would require the non-participating out-of-state providers to convert to in-network status, which would require enrollment in the Pennsylvania Medical Assistance Program.

Enroll by visiting:
https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

The Plan will use the NPI of the ordering, referring or prescribing provider included on the rendering provider's claim to validate the provider's enrollment in the Pennsylvania MA program.

A claim submitted by the rendering provider will be denied if it is submitted without the ordering/prescribing/referring provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA provider.

The Health Care Provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

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

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

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

Family Planning

Members are covered for Family Planning Services without a referral or Prior Authorization from the Plan. Members may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Plan's Network. Members that have questions or need help locating a Family Planning Services provider can be referred to AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200**.

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

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

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

Sterilization

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

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

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

- 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

DHS's Sterilization Consent Form must accompany all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions and can either be submitted electronically via Change Healthcare attachments (275 transactions) or mailed to the address below. The claim and consent forms will be retained by the Plan.

Submit claims to:
AmeriHealth Caritas Pennsylvania Family Planning
P.O. Box 7118
London, KY 40742

Home Health Care

The Plan encourages home health care as an alternative to hospitalization when medically appropriate. Home health care services are recommended:

- To allow an earlier discharge from the hospital.
- To avoid unnecessary admissions of Members who could effectively be treated at home.
- To allow Members to receive care when they are homebound, meaning their condition or illness restricts their ability to leave their residence without assistance or makes leaving their residence medically contraindicated.

Home Health Care should be utilized for the following types of services:

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

The Plan's **Integrated Care Management Department (ICM)** will coordinate Medically Necessary home care needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. Contact AmeriHealth Caritas Pennsylvania's Integrated Care Management Department at **1-877-693-8271**, For Home Infusion care, please call AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622.**

All Home Health Agencies are required to send weekly missed shift reports via email to shiftcaremailbox@amerihealthcaritas.com for AmeriHealth Caritas Pennsylvania members.

All Home Health Agencies are required to validate any home health service provided to members using Electronic Visit Verification (EVV) prior to submitting claims. Providers must meet the EVV compliance thresholds established by DHS.

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

Hospice Care

If a Member requires hospice care, the PCP should contact the Plan's Utilization Management Department. The Plan will coordinate the necessary arrangements between the PCP and the hospice provider in order to ensure receipt of Medically Necessary care.

Call AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622**.

Hospital Transfer Policy

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

Elective inter-facility transfers must be prior authorized by AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622.**

These steps must be followed by the Health Care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient
- Have an accepting physician in the receiving hospital

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

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

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

Hysterectomies

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

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

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

DHS's Sterilization Consent Form must accompany all claims for reimbursement for hysterectomy services. The form must be completed correctly in accordance with the instructions instructions and can either be submitted electronically via Change Healthcare attachments (275 transactions) or mailed to the address below. The claim and consent forms will be retained by the Plan.

Submit claims to:
AmeriHealth Caritas Pennsylvania
P.O. Box 7118
London, KY 40742

Medical Supplies

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

- Vaporizers (one per 365 days)
- Humidifiers (one per 365 days)
- Diapers/Pull-Up Diapers (Incontinence supplies are not provided through participating pharmacies) may be obtained as follows:
    - The Plan has partnered with J&B Medical Supply to supply incontinence supplies to Members.
    - J&B Medical Supply will deliver incontinence supplies directly to a member's home through a drop ship program.
    - Prior authorization is not required when ordering through J&B Medical Supply (1-800- 737-0045).

    - In order for the Member to obtain incontinence supplies through J&B Medical Supply, Network Providers must complete a J&B Medical Supply Diaper and Incontinence Supply Form (see Appendix for a sample form).
- Requests for diapers/pull-up diapers supplied by any other DME Network Provider require Prior Authorization
- Members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary. A written prescription from a Network Provider is required. Authorization is required when supplied by any DME network Provider, other than those listed above.
- Diabetic supplies (also available through participating pharmacies)
    - Insulin, disposable insulin syringes and needles
    - Disposable blood and urine testing agents
    - Some continuous glucose monitors (CGMs), CGM supplies and blood glucose meters.
        - Please refer to the Pennsylvania Department of Human Services Statewide Preferred Drug List (PDL) for the current preferred products and quantity limits.
    - Lancets, control solution and strips
    - Glucose tablets, alcohol swabs
- Blood pressure monitors less than $80 are covered under the Plan pharmacy benefit with a prescription. Coverage is currently limited to one (1) unit per 365 days
- Spacers are covered under the Plan's pharmacy benefit. Quantity limits are two per 365 days. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Peak flow meters (one per 365 days). Requests that exceed these limits should be referred to the Utilization Management Department for medical necessity review.

Newborn Care

The Plan assumes financial responsibility for services provided to newborns of mothers who are active Members. However, these newborns are not automatically enrolled in the Plan at birth.

The hospital should complete and submit an MA-112 form to DHS whenever a Member delivers. (This form can be found in the Appendix or on the Provider Center at **www.amerihealthcaritaspa.com**.) The newborn cannot be enrolled in the Plan until DHS opens a case and lists him/her as eligible for Medical Assistance.

Processing of newborn Claims will be delayed pending DHS's completion of this process. However, in order to protect the Health Care Provider's timely filing rights, facility charges for newborn care can be billed on a separate invoice using the mother's Plan ID number but with the newborn's name and date of birth. These Claims will be pended until the newborn number is available. The Plan will pay newborn charges according to the hospital's contracted rates.

Health Care Provider charges for circumcision and inpatient newborn care must be billed under the newborn's Plan ID number.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screens must be completed on every newborn, and submitted to the Plan's Claims Processing Department. Please refer to the Pediatric Preventative Health Care Program in this section of the manual for EPSDT instructions.

Detained Newborns and Other Newborn Admissions

With the exception of newborns that will be billed using -APR-DRG 640X, facilities are generally required to notify the Plan of all newborn admissions, including, but not limited to, in the following circumstances:

- The Plan regards a baby detained after the mother's discharge as a new admission. The admission must be reported to the Plan's Utilization Management Department and a new case reference number will be issued for the detained baby.
- Facilities are required to notify the Plan of all admissions to an Intensive Care or Transitional Nursery within 24 hours of the admission (even if the admission does not result in the baby being detained).
- Facilities are also required to notify the Plan of all newborn admissions where the payment under their contract will be at other than the newborn rate associated with APR-DRG 640X (even if the baby is not detained or admitted to an Intensive Care or Transitional Nursery).

In order to simplify the notification process and provide the best utilization management of our detained neonatal population, a special call center has been established to receive notifications 7 days a week, 24 hours a day.

Facilities should call AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622** and follow prompts. When calling in detained baby or other newborn admission notifications, please be prepared to leave the following information:

- Mother's first and last name
- Mother's Plan First ID #
- Baby's first and last name
- Baby's date of birth (DOB)
- Baby's sex
- Admission date to Intensive Care/Transitional Nursery
- Baby's diagnosis
- First and last name of baby's attending practitioner
- Facility name and Plan-assigned ID #
- Caller's name and complete phone number

Upon review and approval, a Utilization Management Coordinator will contact the facility and provide the authorization number assigned for the baby's extended stay or other admission. **All facility and associated practitioner charges should be billed referencing this authorization number.**

The Plan will pay detained newborn or other newborn admission charges according to established hospital-contracted rates or actual billed charges, whichever is less, for the bed-type assigned (e.g., NICU) commencing with the day the mother is discharged from the hospital. A new admission with a new case reference number will be assigned for the detained newborn or newborn admitted for other reasons. All detained baby or other newborn admission charges must be billed on a separate invoice.

Nursing Facility Covered Services

If a Member needs to be referred to a Nursing Facility, the PCP or representative from the transferring hospital should contact the Plan's Utilization Management Department. The Plan will assist in coordinating the submission of the completed MA-51 to the local Area Agency on Aging to initiate the Functional Eligibility Determination (FED) in order to provide the needed care.

The FED was implemented by DHS to identify individuals who are reviewed by the local Area Agency on Aging and considered eligible for long-term care using two criteria: (1) must be over 21 years of age and (2) meet the criteria for nursing home level of care. Once the FED Assessment is completed Members may qualify for long-term care if they have multiple needs, which may include: severe mental health conditions; severe developmental delays/Intellectual Disability conditions; paraplegia/quadriplegia; elderly. The Plan is not responsible for providing or paying for the FED. Network Providers are responsible for contacting the Area Agency on Aging to initiate an FED for a Member in need of long-term care in a nursing home. The phone numbers for the Area Agencies on Aging are:

AmeriHealth Caritas Pennsylvania Counties:

Adams County Office of Aging	**1-717-334-9296**
Allegheny County Office of Aging	**1-412-350-4234**
Armstrong County Office of Aging	**1-724-548-3290**
Beaver County Office of Aging	**1-724-847-2262**
Bedford County Office of Aging	**1-814-623-8148**
Berks County Office of Aging	**1-610-478-6500**
Blair County Office of Aging	**1-814-946-1235**
Bradford County Office of Aging	**1-570-265-6121**
Butler County Office of Aging	**1-724-282-3008**
Cambria County Office of Aging	**1-814-539-5595**
Cameron County Office of Aging	**1-814-776-2191**
Carbon County Office of Aging	**1-800-441-1315**
Centre County Office of Aging	**1-814-355-6716**
Clarion County Office of Aging	**1-814-226-4640**

Clearfield County Office of Aging	**1-814-765-2696**
Clinton County Office of Aging	**1-570-326-0587**
Columbia County Office of Aging	**1-570-784-9272**
Crawford County Office of Aging	**1-814-336-1792**
Cumberland County Office of Aging	**1-717-240-6110**
Dauphin County Office of Aging	**1-717-780-6130**
Elk County Office of Aging	**1-814-776-2191**
Erie County Office Aging	**1-814-459-4581**
Fayette County Office of Aging	**1-724-489-8080**
Forest County Office of Aging	**1-814-723-3763**
Franklin County Office of Aging	**1-717-263-2153**
Fulton County Office of Aging	**1-717-485-5151**
Greene County Office of Aging	**1-724-489-8080**
Huntingdon County Office of Aging	**1-814-643-5115**
Indiana County Office of Aging	**1-724-349-4500**
Jefferson County Office of Aging	**1-814-849-3096**
Juniata County Office of Aging	**1-717-242-0315**
Lackawanna County Office of Aging	**1-570-963-6740**
Lancaster County Office of Aging	**1-717-299-7979**
Lawrence County Office of Aging	**1-724-658-3729**
Lebanon County Office of Aging	**1-717-273-9262**
Lehigh County Office of Aging	**1-610-782-3034**
Luzerne County Office of Aging	**1-570-822-1158**
Lycoming County Office of Aging	**1-570-326-0587**
McKean County Office of Aging	**1-814-776-2191**
Mercer County Office of Aging	**1-724-662-6222**
Mifflin County Office of Aging	**1-717-242-0315**
Monroe County Office of Aging	**1-570-420-3735**
Montour County Office of Aging	**1-570-784-9272**
Northampton County Office of Aging	**1-610-829-4540**
Northumberland County Office of Aging	**1-570-495-2395**
Perry County Office of Aging	**1-717-582-5128**
Pike County Office of Aging	**1-570-775-5550**

Potter County Office of Aging	**1-814-544-7315**
Schuylkill County Office of Aging	**1-570-622-3103**
Snyder County Office of Aging	**1-570-524-2100**
Somerset County Office of Aging	**1-814-443-2681**
Sullivan County Office of Aging	**1-570-946-4316**
Susquehanna County Office of Aging	**1-570-278-3751**
Tioga County Office of Aging	**1-570-723-0935**
Union County Office of Aging	**1-570-524-2100**
Venango County Office of Aging	**1-814-432-9711**
Warren County Office of Aging	**1-814-723-3763**
Washington County Office of Aging	**1-724-489-8080**
Westmoreland County Office of Aging	**1-724-830-4444**
Wayne County Office of Aging	**1-570-253-4262**
Wyoming County Office of Aging	**1-570-822-1158**
York County Office of Aging	**1-717-771-9610**

It should be noted, per the Plan's agreement with DHS, that:

- **Residence in a nursing facility is not cause for disenrollment from the Plan.**
- **The Plan is responsible for nursing facility services so long as the Member is enrolled in the Plan. Once the Plan is notified that a Member has been determined Nursing Facility Clinically Eligible (NFCE), despite not being enrolled in CHC at the time, the Plan would continue to be responsible to provide nursing facility benefits and all other covered health benefits from the thirty-first (31st) day forward. For days from the 31st day forward, the Utilization Management department (UM) will review skilled nursing facility (SNF) admissions based on medical necessity review for the SNF level of care from the admission date through the discharge date or if there is a medical necessity denial from a Medical Director, whichever is sooner.**
- **If eCIS provides a CHC start date and if the Plan's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the same month, the last day of the Plan's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date.**

To report admission of a Member, Nursing Facilities should call the Plan's Utilization Management Department as soon as possible, prior to or after admission. In the event that verification is subsequently needed to document that the Nursing Facility notified the Plan of the admission of one of its Members, the Nursing Facility should follow up on the initial contact to the Plan with written correspondence to:

AmeriHealth Caritas Pennsylvania Utilization Management Department
8040 Carlson Road
Harrisburg, PA 17112

Obstetrical/Gynecological Services

Direct Access

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

Bright Start® Maternity Program Overview

AmeriHealth Caritas Pennsylvania offers a perinatal Care Management program, called Bright Start Maternity Program, to pregnant Members. The goal of the program is to reduce infant morbidity and mortality among Members. The Bright Start Maternity Program is comprised of nurses and administrative staff who actively seek to identify pregnant Members as early as possible in their pregnancy, and continue to follow them through their post-delivery period.

Obstetrician's Role in Bright Start® Maternity Program

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

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

AmeriHealth Caritas PA only accepts ONAF forms that are submitted through the Optum website. To register and get started submitting electronically visit: **https://obcare.optum.com/**

The OB Care User Guide and link to the OPTUM website is also available at: **www.amerihealthcaritaspa.com → Providers → Initiatives → Bright Start → Provider Information, Resources, and Tools**.

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

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

In order for the Plan to successfully assist our pregnant members, we look to partner and collaborate with our Plan's OB Providers. For support, resources, or further information on the Bright Start Maternity Program, please contact the AmeriHealth Caritas Pennsylvania Bright Start Maternity Department at **1-877-364-6797.**

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

For behavioral health and substance use disorder resources, including information about Centers of Excellence and resources for pregnant members with substance use disorders, please refer to our websites at **www.amerihealthcaritaspa.com.**

Ophthalmology Services

Non-Routine Eye Care Services

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

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

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

Outpatient Laboratory Services

When an AmeriHealth Caritas PA patient requires outpatient lab tests or processing of lab specimens, you have the following choices:

- Send them to Labcorp; or
- Send them to Quest Diagnostics; or
- Utilize any AmeriHealth Caritas PA participating laboratory, or participating hospital outpatient laboratory

As a reminder, AmeriHealth Caritas PA member ID cards no longer have an indication of a specific lab to use.

- The Plan highly recommends that pre-admission laboratory testing be completed by the Primary Care Physician. However, testing can be completed at the hospital where the

procedure will take place, and does not require a referral from AmeriHealth Caritas Pennsylvania.

- **STAT labs must only be utilized for urgent problems.** The ordering physician may give the member a prescription form or Plan procedure confirmation form to present to the participating facility.
    - The PCP is responsible for including all demographic information when submitting laboratory testing request forms. For a listing of Quest Patient Service Centers, please contact AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** or go to **www.questdiagnostics.com**.

Outpatient Renal Dialysis

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

Free-Standing Facilities

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

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

Hospital-Based Outpatient Dialysis

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

Associated provider services (Nephrologist or other Specialist) require a referral that must be initiated by the PCP. Once the treatment plan has been authorized, the Specialist may "expand" the initial referral by contacting AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

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

- Supplies and equipment for home dialysis patients (Method II)

- Home care support services provided by an RN or LPN
- Transplants and transplant evaluations
- All inpatient dialysis procedures and services

Outpatient Testing

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

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialist should note the Member's information and procedures to be performed on his/her office prescription form. Refer to **"Prior Authorization Requirements**" section of the Manual for a complete list of procedures requiring Prior Authorization.

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

Outpatient Therapies

Physical, Occupational, and Speech

Members are entitled to 24 physical, 24 occupational, and 24 speech therapy outpatient visits (per discipline) within a calendar year. A referral from the Member's PCP is required for the initial visit to the therapist. Initial visits are not considered part of the 24 visits.

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Liaisons in the EPSDT Department assist the Parents or Guardians of all Members younger than twenty-one (21) years of age in receiving EPSDT screens, treatment, follow-up, and referrals to the Early Intervention Program when appropriate. The EPSDT liaison also facilitates and ensures

EPSDT compliance, provides follow-up concerning service issues, educates non-compliant Members on the Plan's rules and regulations, and assists Members in accessing care.

The quantity of Medically Necessary, Title XIX eligible services for enrolled children younger than twenty-one (21) years of age are not restricted or limited.

EPSDT Screens

Per the HealthChoices agreement, the Plan must provide and/or arrange for the promotion of services to eligible children younger than twenty-one (21) years of age that include comprehensive, periodic preventive health assessments. All Medically Necessary immunizations are required. Age appropriate assessments, known as "screens," must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever a health care provider suspects the child may have a health problem. Treatment for all Medically Necessary services discovered during an EPSDT screening is also covered.

EPSDT Screens must include the following:

- A comprehensive health and developmental history, including both physical and mental health development
- A comprehensive unclothed exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests including blood lead level assessment
- Health education including anticipatory guidance

EPSDT Covered Services

The following services are covered under the EPSDT Program:

Comprehensive screens according to a predetermined periodicity schedule (found in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**):

- Children ages birth through 30 months should have screening visits at the following intervals: by 3-5 days, 0-1 months, 2-3 months, 4-5 months, 6-8 months, 9-11 months, 12, 15, 18, 24 and 30 months. The most current Periodicity Schedule is posted on the EPSDT section of the Provider site.
- Children and adolescents ages 3 years to 21 years of age are eligible for annual screens.

After completion of a screen, Members are entitled to all services included in the approved DHS State Plan for diagnosing and treating a discovered condition. Included in this plan are:

- Eye Care
- Hearing Care, including hearing aids
- Dental Care
    - At 6-8 and 9-11 months, an oral health risk assessment is to be administered and the need for fluoride supplementation assessed. The first dental examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. At 12, 18, 24, and 30 months, determine if child has a dental home. If not, complete assessments and refer to dental home.
    - Beginning at 3 years of age, referral to a dental home is a required screening component and must be reported using the YD referral code.

In addition, the Plan will pay for routine health assessments, diagnostic procedures, and treatment services provided by Network Providers and clinics, as well as vision and hearing services, and dental care, including orthodontics.

The Plan complies with the relevant OBRA provisions regarding EPSDT by implementing the following:

- Health education is a required component of each screening service. Health education and counseling to parent (or guardian) and children is designed to assist in understanding what to expect in terms of the child's physical and cognitive development. It is also designed to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention.
- Screening services are covered at intervals recommended by the Academy of Pediatrics and the American Dental Association. An initial screening examination may be requested at any time, without regard to whether the member's age coincides with the established periodicity schedule.
- Payment will be made for Medically Necessary diagnostic or treatment services needed to correct or ameliorate illnesses or conditions discovered by the screening services, whether or not such diagnostic or treatment services are covered under the State Medicaid Plan and provided that it is covered under Title XIX of the Social Security Act. However, Network Providers should be aware that any such service must be prior-authorized and that a letter of medical necessity is required.

EPSDT Expanded Services

EPSDT Expanded Services are defined as any Medically Necessary health care services provided to a Medical Assistance recipient younger than twenty-one (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, for example. Additional information on EPSDT Screening Requirements is located in the later portion of this section.

Eligibility for EPSDT Expanded Services

All Members younger than twenty-one (21) years of age are also 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 the Plan benefits.

EPSDT Expanded Services Requiring Prior Authorization

EPSDT Expanded Services require Prior Authorization. All requests for EPSDT Expanded Services should be forwarded to The Plan's Utilization Management Department 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. Although Utilization Management will accept letters of medical necessity from a Member's PCP, a participating Specialist or Ancillary Health Care Provider, the PCP will be asked to approve the treatment plan.

EPSDT Expanded Services Approval Process

When the Plan's 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 AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622** for a case reference number. The provider of service will be responsible for conducting Concurrent Reviews with the Plan's Clinical Service's Department to obtain authorization to extend the approval of services. 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 Plan's Medical Director or his/her designee will make a good faith effort, 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 how the decision can be appealed and for Members, information on how to contact community legal service agencies who might be able to assist in filing the Grievance.

The Plan 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 the Plan. The Health Care Provider of service is responsible for forwarding documentation of the prior approval in order for the Plan to continue to authorize previously approved services. The Plan 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.

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS 1500 or UB-04 paper claim forms or electronically, using the 837 format.

Providers choosing to bill for complete EPSDT screens, including immunizations, on the CMS 1500 or UB-04 claim form or the 837 electronic formats must:

- **Use Z76.1, Z76.2, Z00.111, Z00.121, Z00.129, or Z38.01- Z38.3-Z38. 1 as the primary diagnosis code**
- **Use diagnosis codes Z00.00 or Z00.01 for Members aged 15 to 21 years of age**
  Providers may use the following additional ICD-10 diagnosis codes in conjunction with ESPDT claims:
- Z00.110 (Health examination for newborn under 8 days old)
- Z00.111 (Health examination for newborn 8 to 28 days old)
- Z38.00 (Single live born infant, delivered vaginally)
- **Z38.01 (Single live born infant, delivered by cesarean)**
- Z38.1 (Single live born infant, born outside hospital)
- Z38.2 (Single live born infant, unspecified as to place of birth)
- **Z38.3-Z38.8 (Range of codes for multiple births)**
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 - Outpatient Lab; U1 - Autism.
    - Use U1 modifier in conjunction with CPT code 96110 for Autism screening.
    - CPT code 96110 without a U1 modifier is to be used for a Developmental screening.

Age Appropriate Evaluation and Management Codes

(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:

99460 Newborn Care (during the admission)

99463 Newborn (same day discharge)

New Patient:		**Established Patient:**	
99381	Age < 1 yr.	99391	Age < 1 yr.
99382	Age 1-4 yrs.	99392	Age 1-4 yrs.
99383	Age 5-11 yrs.	99393	Age 5-11 yrs.
99384	Age 12-17 yrs.	99394	Age 12-17 yrs.
99385	Age 18-20 yrs.	99395	Age 18-20 yrs.

Billing example: New Patient EPSDT screening for a 1 month old-The diagnosis and procedure code for this service would be:

- Z76.2 (Primary Diagnosis)
- 99381EP (E&M Code with "Complete" modifier)

Enter a zero ($0.00) or actual charged amount (including capitated services). A blank is not valid and will be rejected.

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. Both are available in a printable PDF format online at the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com.**

Completing the CMS 1500 or UB-04 Claim Form

The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:

- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier
- EPSDT/Family Planning

UB- 04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use EPSDT Referrals	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. **YD – Dental *(Required for ages 3 and over)** **YO – Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through**	 C C

UB- 04	CMS 1500	Item	Description	C/R
			the CONNECT Early Intervention Helpline at 1-800-692-7288, document the referral in the child's medical record and submit the YO EPSDT referral code. **YV – Vision** **YH – Hearing** **YB – Behavioral** **YM – Medical**	 C C C C
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, **diagnosis code Z76.1, Z76.2, Z00.121, Z00.129, Z00.00 Z00.01, Z00.110, Z00.111, Z38.01, Z38.1 or Z38.3-Z38.8** must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. **An appropriate diagnosis code must be included for each referral.** Immunization Codes are not required. **EXCEPTION** when billing for newborns in an inpatient setting (Place of Service 21). Please use diagnosis code Z38.00, Z38.01, Z38.1, Z38.2 or Z38.30-Z38.8 in the primary field with Z00.110, Z00.111, Z00.121, Z00.129, Z76.1 or Z76.2 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting.	
42	N/A	Revenue code	Enter Revenue **Code 510**	R

UB- 04	CMS 1500	Item	Description	C/R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a "complete" EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	**Enter Visit Code 03** when providing EPSDT screening services.	R

Key:

- **Block Code –** Provides the block number as it appears on the claim.
- **C** – Conditional must be completed if the information applies to the situation or the service provided.
- R – Required – must be completed for all EPSDT claims.

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Screening Eligibility and Required Services

For screening eligibility information and services required for a complete EPSDT screen, please consult the:

- EPSDT Program Periodicity Schedule and Coding Matrix
- Recommended Childhood Immunization Schedule

(Both schedules are available in the Appendix of the Manual and in a printable PDF format in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**).

You may direct EPSDT program specific questions to the Plan's EPSDT Outreach Department at **1-855-300-8334.**

Family and Medical History for EPSDT Screens

It is the responsibility of each Network Provider to obtain a Family and Medical History as part of the initial well-child examination.

The following are the Family and Medical History categories, which should be covered by the Network Provider:

- Family History
    - Hereditary Disorders, including Sickle Cell Anemia
    - Hay fever - Eczema - Asthma
    - Congenital Malformation
    - Malignancy - Leukemia
    - Convulsions - Epilepsy
    - Tuberculosis
    - Neuromuscular disease
    - Intellectual Disabilities
    - Mental Illness in parent requiring hospitalization
    - Heart disease
    - Details of the pregnancy, birth and neonatal period
    - Complication of pregnancy
    - Complication of labor and delivery
    - Birth weight inappropriate for gestational age
    - Neonatal illness
- Medical History
    - Allergies, Asthma, Eczema, Hay Fever
    - Diabetes
    - Epilepsy or convulsions
    - Exposure to tuberculosis
    - Heart Disease or Rheumatic Fever
    - Kidney or Bladder problems
    - Neurological disorders
    - Behavioral disorders
    - Orthopedic problems
    - Poisoning
    - Accidents
    - Hospitalizations/Operations
    - Menstrual history
    - Medication

Height

Height must be measured on every child at every well-child visit. Infants and small children should be measured in the recumbent position, and older children standing erect. The height should be recorded in the child's medical record and should be compared to a table of norms for age. The child's height percentile should be entered in the child's medical record. Further study or referral is indicated in a child who has deviated from his/her usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th or below the 3rd percentile).

Weight

Weight must be measured on every child at every well-child visit. Infants should be weighed with no clothes on, small children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight should be recorded in the child's medical record, and should be compared to a table of norms for age. The child's weight percentile should also be entered in the child's medical record. Further study or referral is indicated for a child who has deviated from his usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th percentile or below the 3rd percentile).

Head Circumference

Head circumference should be measured at every well-child visit on infants and children up to the age of two years. Measurement may be done with cloth, steel or disposable paper tapes. The tape is applied around the head from the supraorbital ridges anteriorly, to the point of posteriorly giving the maximum circumference (usually the external occipital protuberance). Further study or referral is indicated for the same situations described in height and weight, and findings should be recorded in the child's medical record.

Blood Pressure

Blood pressure must be done at every visit for all children older than the age of three (3) years, and must be done with an appropriate-sized pediatric cuff. It may also be done under the age of three years when deemed appropriate by the attending Network Provider. Findings should be recorded in the child's medical record.

Dental Screening

Per the American Academy of Pediatric Dentistry, the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease. ***All children ages 3 and above must be referred for an annual dental exam as part of each EPSDT Screening.*** Providers should check for the following and initiate treatment or refer as necessary:

- Cavities
- Missing Permanent Teeth
- Fillings present
- Oral infection
- Other Oral Concerns

In completing a dental referral for all children age 3 and above:

- Providers should advise the child's parent or guardian that a dental exam is required according to the periodicity schedule.
- The Provider should complete and fax the EPSDT Dental Referral Notification form (available under Forms on the Provider Center of **www.amerihealthcaritaspa.com** or contact AmeriHealth Caritas Pennsylvania Member Services at **1-800-991-7200** while the member is in the office, or within four (4) business days of the visit to notify them that the child is due for a dental exam as part of a complete EPSDT screen.
- Either method of notification fulfills the requirement for the Provider to refer the member to a dental home. AmeriHealth Caritas Pennsylvania Member Services will then coordinate with the member and their family to locate a participating dentist and arrange an appointment for the child.
- Documentation of the dental referral should be recorded in the child's medical record and on the claim form by utilizing the appropriate EPSDT dental referral code.

Dental Referral:

- Use the EPSDT modifier EP (Complete Screen) when the process outlined above has been followed.
- Enter the EPSDT referral code YD (dental referral) in field 10d on the CMS 1500 claim form, or field 37 on the UB-04 form.
- When the dental referral has not occurred, submit the claim with the EPSDT modifier 52 (Incomplete Screen).
- *Payment for a complete screen is determined by the presence of both the EP modifier and YD referral code.

Important note: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

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

Vision Testing

Vision testing must be administered at 3, 4, 5, 6, 8, 10, 12, and 15 years of age.

Technique Tips for Vision Testing

The chart should be affixed to a light-colored wall, with adequate lighting (10-30 foot candles) and no shadows. Ordinary room lighting usually does not provide this much light and the chart will need a light of its own. The 20-foot line on the chart should be set at approximately the level of the

eyes of a six (6) year old. Placement of the child must be exactly at 20-feet. Sites that do not have a 20-foot distance at which to test should obtain a 10-foot Snellen chart rather than convert to the 20-foot chart. The eye not being tested must be covered with an opaque occluder; several commercial varieties are available at minimal cost, or the Network Provider may improvise one. The hand may not be used, as it leads to inaccuracies. In older children who seem to have difficulty or in young children, bring the child up to the chart (preferably before testing), explain the procedure and be sure the child understands.

For screening, the tester should start with the big E (20-foot line) and then proceed down rapidly line-by-line, as long as the child reads one letter per line, until the child cannot read. At this critical level, the child is tested on every letter on that line or adjacent line. Passing is reading a majority of letters in a line. It is not necessary to test for every letter on the chart. Tests for hyperopia may be done but are not required.

Referral Standards

Children seven (7) years of age and older should be referred if vision in either eye is 20/30 or worse. Those six (6) and younger should be referred if vision in either eye is 20/40 or worse. A child may be referred if parental complaints warrant or if the doctor discovers a medical reason. (Generally, sitting close to television, without other complaints and with normal acuity, is not a reason for referral.) Children failing a test for hyperopia may be referred.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further need be done. If they fail, refer for re-evaluation to a Plan participating Specialist, preferably to the vision provider who prescribed the lenses, regardless of when they were prescribed.

If the Network Provider is unable to render an eye examination, in a child nine (9) years of age or older, because of the child's inability to read the chart or follow directions (e.g., a child with Intellectual Disability/ies), please refer this child to a participating Ophthalmologist.

Hearing Screening

Hearing Screening must be administered at the newborn inpatient visit. If the hearing screening is not performed during this visit, it should be performed at the 1 or 2-3 month visit. Screenings thereafter should follow the most current periodicity schedule.

Technique Tips for Hearing Testing

Tuning forks and un-calibrated noisemakers are not acceptable for hearing testing. For children younger than five (5) years of age, observation should be made of the child's reactions to noises and to voices, unless the child is sufficiently cooperative to actually do the audiometry. For audiometry, explain the procedure to the child. For small children, present it as a game. Present one tone loud

enough for the child to hear, and explain that when it is heard, the child should raise his/her hand and keep it raised until the sound disappears. Once the child understands, proceed to the test.

Doing one ear at a time, set the decibel level at 25, and testing at 500 HZ. Then go successively to 1000, 2000, 4000 and 6000. Repeat for the other ear. The quietest room at the site should be used for testing hearing.

Referral Standards

Any cooperative child failing sweep audiometry at any two frequencies should be referred to an otorhinolaryngologist or audiologist. If a child fails one tone, retest that tone with threshold audiometry to be certain it is not a severe single loss. To be certain of the need for referral, the Network Provider should immediately retest all failed tones by threshold audiometry, or, if there is question about the child's cooperation or ability at the time of testing, bring the child back for another sweep audiometry before referring. Please remember that audiometers should be periodically (at least yearly) calibrated for accuracy.

Development/Behavior Appraisal

Since children with slow development and abnormal behavior may be able to be successfully treated if treatment is begun early, it is important to identify these problems as early as possible. Questions must be included in the history that relate to behavior and social activity as well as development. Close observation is also needed during the entire visit for clues to deviations in those areas. The completion of a structured developmental screen is required for ages 9 – 11 months, 18 months and 30 months. Use procedure code 96110 to report the completion of this screen.

Younger than five (5) years of age

In addition to history and observation, some sort of developmental evaluation should be done. In children who are regular patients of the Network Provider site, this may consist of on-going recording, in the child's chart, of development milestones sufficient to make a judgment on developmental progress. In the absence of this, the site may elect to do a Denver Developmental Test as its evaluation.

- Marked slowness in any area should be cause for a referral to a participating Specialist, e.g., developmental center, a MH/MR agency, a development Specialist, a pediatric neurologist or a psychologist. If only moderate deficiencies in one or more areas are found, the child should be re-tested in 30-60 days by the Network Provider.
- Social Activity/Behavior - Questions should be asked to determine how the child relates to his family and peers and whether any noticeable deviation in any of his/her behavior exists. The Network Provider should observe for similar behavior in the office.

- Speech Development - Attention should be paid to the child's speech pattern to see whether it is appropriate for age. The DASE test may be used as an evaluation.

Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through CONNECT Helpline at **1-800-692-7288** and document the referral in the child's medical record.

For information on the Early Intervention System, please refer to the Special Healthcare Needs and Care Management section of this Manual.

Five (5) years of age and older

Since the usual developmental tests are not valid at this age, observation and history must be used to determine the child's normality in the areas listed below. Each child should be checked and recorded appropriately. Major difficulty in any one area, or minor difficulty in two or more areas, should be cause for referral to a participating mental health professional for further diagnosis.

- Social Activity/Behavior - Does the child relate with family and peers appropriately?
- School - Is the child's grade level appropriate for his/her age? Has the child been held back in school?
- Peer Relationships
- Physical/Athletic Dexterity
- Sexual Maturation -Tanner Score.
- Speech - DASE Test if there is a problem in this area record accordingly, refer appropriately

Autism Screening

A structured autism screen is required at ages 18 months and 24 months. Use procedure code 96110, and modifier U1 to report the completion of this screen.

See the Appendix for a complete and updated guide of requirements and resources for structured screening for developmental delays and autism spectrum disorder.

Children on SSI under the age of 21

With respect to SSI and SSI-related Members under the age of 21, at the first appointment following enrollment, the PCP must make an initial assessment of the health needs of the child over an appropriate period (not to exceed one year), including the child's need for primary and specialty care. The results of that assessment shall be discussed with the family or custodial agency (and, if appropriate, the child) and shall be listed in the child's medical records. The family shall be informed in writing of the plan, and the right to use complaint procedures if they disagree. As part of the initial assessment, the PCP shall make a recommendation regarding whether Care

Management Services should be provided to the child, based on medical necessity, and with the families or custodial agency's consent, this recommendation shall be binding.

Anemia Screening

Initial measurement of hemoglobin or hematocrit is recommended between 9 and 11 months of age, and required by the 12-month screen. After this, a hematocrit should only be performed if indicated by risk assessment and/or symptoms. All premature or low-birth weight infants should have hemoglobin or hematocrit done on their first well-visit and then repeated according to the schedule above. The results of the test should be entered in the child's medical record.

Diagnosis of anemia should be based on the doctor's evaluation of the child and the blood test. It is strongly suggested that a child with 10 grams of hemoglobin or less (or a hematocrit of 30% or less) be further evaluated for anemia. However, even though 10 grams may represent the lower limit of norm for most of childhood, it should be realized that in early infancy and adolescence these levels should be higher. For those Network Providers who use charts to evaluate hemoglobin/hematocrit normals, it should be emphasized that average or mean Hb/Ht for age is not the level to determine anemia, but rather two standard deviations below the mean.

Sickle Cell

Infants younger than 8 months of age with African-American, Puerto Rican, or Mediterranean parentage should have a sickle test on their first well-child visit, to determine the possibility of sickle cell disease being present. After that age, all children of African-American, Puerto Rican, or Mediterranean parentage should have a sickle test only if they exhibit symptoms of anemia or have an Hb/Ht below the normal levels outlined above, unless they have already been tested and the results are known.

Tuberculin (TB) Test

The American Academy of Pediatrics recommends that a child at high risk for TB exposure should be tested for tuberculosis annually, using the Mantoux test. High risk is identified as:

- Contacts with adults with infectious tuberculosis
- Those who are from, or have parents from, regions of the world with high prevalence of tuberculosis
- Those with abnormalities on chest roentgenogram suggestive of tuberculosis
- Those with clinical evidence of tuberculosis
- HIV seropositive persons
- Those with immunosuppressive conditions
- Those with other medical risk factors: Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure, malnutrition
- Incarcerated adolescents
- Children frequently exposed to the following adults: HIV infected

individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, migrant farm workers.

Children with no risk factors who live where TB is not common do not need TB tests. Children at high risk (see list above) should be tested every year.

Children who live in places where TB is common or whose risk is uncertain may be tested at 1, 4, 6 and 11-16 years of ages. For example, Philadelphia has twice as much TB as the national average, so children in Philadelphia should receive Mantoux tests at 1, 4, 6 and 11-16 years of age at least.

It is the responsibility of the PCP's office to secure the results of the TB Test forty-eight to ninety-six (48-96) hours after it has been administered. TB Testing should begin at twelve (12) months, or first well-child visit thereafter, and then at two (2) year intervals, (or yearly, if high risk). Results should be entered in the child's medical record.

Albumin and Sugar

Tests for urinary albumin and sugar should be done on every child routinely at every well-visit. Dip sticks are acceptable. Positive tests should be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

Cholesterol Screening

Cholesterol (Dyslipidemia) screening is a required component at 9, 11 and 18 years of age; if not completed at the 18 year screening it must be done at either the 19 or 20 year screening.

Lead Level Screening

The incidence of asymptomatic Undue Lead Absorption in children six (6) months to six (6) years of age is much higher than generally anticipated. The Centers for Medicare and Medicaid Services (CMS) and the Pennsylvania Department of Human Services (DHS) have stringent requirements for Lead Toxicity Screening for all Medicaid eligible children.

- ALL Medicaid eligible children are considered at risk for lead toxicity and MUST receive blood lead level screening tests for lead poisoning.
- PCP's are REQUIRED (regardless of responses to the lead screening questions) to insure that children be screened for lead toxicity from nine months to eighteen months and again from two to six years of age.
- Risk questions should be asked at every visit thereafter.
- Refer to the PA EPSDT Periodicity Schedule in the Appendix for reference or visit the Provider Center at **www.amerihealthcaritaspa.com → Resources → EPSDT** for an electronic copy.

- For more information on Lead Level Screening, visit our webpage at **www.amerihealthcaritaspa.com → Providers → Resources → EPSDT**

The Plan recommends, although not indicated on the periodicity schedule, that lead screens be done at nine (9) months of age and again before the second birthday and risk questions asked at every visit thereafter.

As an added incentive to help PCPs comply with the above standards, the Plan will reimburse PCPs for blood lead screening services, if they are performed in the PCP's office.

Submit claim(s) with the following CPT code and include modifier 90 for these services:

Billable Service	CPT Code	Fee
Lead Screening	83655	$10.00

Note: This service is only covered when the above-referenced CMS/DHS guidelines are followed. Elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen.

Our representatives are available to you for any questions regarding this problem, its screening details, its diagnosis or its follow-up by calling the EPSDT Outreach Program at **1-888-765-6388.**

Gonorrhea, VDRL, Chlamydia and Pap Smear

These tests are to be performed when, in the judgment of the PCP, they are appropriate. Talk openly and clearly with adolescents about sexual activity. Put them at ease by letting them know that taking a sexual history is an important part of a regular medical exam or physical history. Give assistance, diagnosis, treatment or information as the situation requires.

Bacteriuria

Tests for bacteriuria must be done on any child who has symptoms relating to possible urinary tract involvement. Routinely at every screen the simple Nitrate Test by dip stick is acceptable for bacteriuria testing. Although it is best done on a first morning specimen, it may be done on a random specimen. A single dipstick is available to test for albumin, sugar, and bacteria.

Immunizations

Both State and Federal regulations request that immunizations be brought up to date during health screenings and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the Network Provider's records should show as much immunization history as can be elicited, especially the date of all previous immunizations. This will provide the necessary basis for further visits and immunizations.

The most up-to-date Childhood and Adolescent Immunization and catch-up schedule, as well as the EPSDT Periodicity schedule that providers are required to follow according to applicable MA bulletins are posted on the EPSDT section of the Provider Center at www.amerihealthcaritaspa.com.

The Plan will reimburse for vaccines not provided under the Vaccines for Children Program (VFC) or vaccines administered to Members over the age of 18. When a vaccine is covered under the VFC Program, the Plan will reimburse an administration fee only.

Pharmacy Services

AmeriHealth Caritas Pennsylvania Pharmacy Services	Phone: **1-866-610-2774**	Fax: **1-888-981-5202**

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

All Members have prescription benefits. There may be a co-payment associated with certain medications. Please refer to the "Member Co-payment Schedule" in Section 1 of this Manual and at **www.amerihealthcaritaspa.com**.

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

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

AmeriHealth Caritas Pennsylvania Drug Formulary

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

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

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

PerformRx
P.O. Box 516
Essington, PA 19029
MedicaidFormulary@performrx.com

Please check for the most up-to-date Formulary that is available online in the Provider Center at **www.amerihealthcaritaspa.com → Providers → Resource → Pharmacy Services**.

Medication Covered by Other Insurance

As an agent of the Commonwealth of Pennsylvania Medical Assistance Program, the Plan is always the payor of last resort in the event that a Member receives medical services or medication covered by another payor source. All Claims where there are third-party resources must first be billed to the primary insurer. Claims for the unpaid balance should then be billed to the Plan. Submit all secondary claims for processing. The claim information is used for HEDIS reporting purposes and other quality initiatives.

Pharmacy Prior Authorization Process

To Obtain Prior Authorization:

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

To contact the AmeriHealth Caritas Pennsylvania Pharmacy Services Department:

- Online:
  - **www.amerihealthcaritaspa.com → Providers → Resource → Pharmacy Services → Pharmacy prior authorization**
- By telephone:
  - **1-866-610-2774** between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST); and after business hours, Saturday, Sunday and Holidays
  - The Member Services Department at **1-888-991- 7200**
- By fax: **1-866-981-5202**

The Prior Authorization procedure is as follows:

- Utilizing criteria approved by both the Plan's Pharmacy and Therapeutics Committee and DHS, (hereafter referred to as "Approved Criteria"), the Plan pharmacist reviews the request

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

For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines that the prescriber did not make a good faith effort to submit a complete request, or that the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

- When the Prior Authorization request does not meet the Approved Criteria, the request is forwarded to a Plan Medical Director to review each request and make and communicate a determination within 24 hours.
  - In evaluating the request, the Medical Director generally relies upon information supplied by the prescribers, the Medical Director's medical expertise, and accepted clinical practice guidelines.
- In the event of a denial, the Plan will notify the prescriber by fax, and the Member by mail within 24 hours. The correspondence will outline specifically all Member and Health Care Provider Appeal rights, and if the requested drug is non-preferred/non-formulary and within the scope of the Statewide PDL or the Plan's Formulary, the Plan will list preferred alternatives appropriate for the beneficiary's diagnosis and clinical condition.
- The prescriber or PCP may discuss the Plan's decision with a Plan Clinical Pharmacist or Medical Director during regular business hours (Monday through Friday 8:30am- 6:00pm). For after- hours urgent calls, call the Member Services Department. To speak with a Plan Clinical Pharmacist or Medical Director, please call the Pharmacy Services Department at **1-866-610-2774**.
- Prescribers and Members may obtain Prior Authorization criteria related to a specific denial determination by submitting a written request for the criteria or by calling the Pharmacy Services Department.

To Request Ongoing Medication/Temporary Supplies:

If the request is for an ongoing medication, and the medication is covered by the Medical Assistance Program, the Plan will automatically authorize a 15-day temporary supply of the requested

medication at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the member to take. If the request is for a new medication and the medication is covered by the MA Program, a 5-day temporary supply of medication will automatically be authorized at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the member to take.

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

Pharmacies have been made aware of the temporary supply requirements. If you become aware of a specific pharmacy that is not dispensing a temporary supply, please contact the Pharmacy Services Department at **1-866-610-2774.**

Drugs Requiring Prior Authorization

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

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

Injectable and Specialty Medications

Specialty Drug Program

Specialty drugs are a specific group of medications that include unusually high-cost oral, inhaled, injectable or infused pharmaceuticals. These drugs are typically prescribed for a relatively narrow spectrum of diseases and conditions and are drugs that often require specific distribution and/or handling. Specialty medications may include treatments covered under both the pharmacy benefit and the medical benefit. These products may have very specific clinical criteria and prescribing guidelines that must be followed to ensure appropriate use and outcomes. Compliance with these criteria is managed through the Prior Authorization process. Unless otherwise specified, specialty drugs managed by the Plan Specialty Drug Program require Prior Authorization. Specialty drugs

that are incidental to, and administered during an inpatient hospital or hospital-based clinic stay are not managed through the Plan Specialty Drug Program and may not require Prior Authorization.

Health Care Providers should use specific forms for specialty and injectable medications online at **https://www.amerihealthcaritaspa.com/pharmacy/prior-auth/index.aspx**. The order form must be completed in its entirety and faxed to the Plan Specialty Drug Management Program at **1-888-981-5202.** Failure to submit all requested information could result in denial of coverage or a delay of approval as the result of insufficient information. Providers should inform the Plan members that specialty medications may not be available through a retail pharmacy and that designated specialty pharmacies should be utilized. **Specialty medications can be filled at any specialty pharmacy in the Plan specialty network and should indicate the requested specialty pharmacy on all prior authorization forms.** The pharmacy specialty network listing is available on the pharmacy pages at **https://www.amerihealthcaritaspa.com/pharmacy/pharmacy-directory.aspx.**

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

The provider authorization forms can be obtained by calling the Plan Specialty Pharmacy Services Department at **1-866-610-2774**. They can also be found online in the Provider Center at **www.amerihealthcaritaspa.com**. The forms are updated as needed so please check the website for the latest updates.

To speak to a representative about the Specialty Drug Management Program, please call **1-866-610-2774.**

Bleeding Disorders Management Program Description

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

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

- Provide support to Members needing information and care regarding their disorder.
- Educates members and their families based upon recommendations provided by the Medical and Scientific Advisory Council (MASAC) through the National Hemophilia Foundation (NHF).

- Coordinates services for health care issues, by working with PCPs and other providers to ensure Members get timely needed care.
- Locates community resources; and function as a liaison between the Member, the specialty pharmacy Network, and the hemophilia treatment center/provider.
- Communicates with the Member's treating physician (and the Primary Care Physician if appropriate) when complications are identified that require intervention outside of the scope of the Bleeding Disorders Nurse Care Manager and documents these interactions accordingly in the appropriate system.
- Identifies problems/barriers to the Plan's Care Coordination Team for appropriate care management interventions.
- Assists the member in resolving care issues and/or barriers to services including, but not limited to pharmacy, equipment, PCP and Specialist physician access, outpatient services, home health care services and coordination of transportation for medical appointments.
- Responsible for regular telephone contact with the Member and/or treatment team.
- Aligns its goals and objectives with those of the Hemophilia Treatment Centers (HTC) to ensure continuity and acuity of care.
- Available 24/7 to Specialty Pharmacies, Treating Physician/HTC's, and members if needed.
- Ensure that factor dosage, and days of service are accurate.
- Review the previous month to compare and ensure the new request is accurate.

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

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

The Procedure for Requesting Hemophilia Medications is as follows:

Completed Prior Authorization request form (including current weight). The form is available on the pharmacy prior authorization section of
https://www.amerihealthcaritaspa.com/pharmacy/prior-auth/index.aspx

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

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

Blood factor products that are subject to review include Factor VII (Novoseven), Factor VIII, Factor IX, Factor FXIII and Anti-Inhibitor Coagulant Complex as well as the monoclonal antibody Hemlibra and any other products as per requirements of the Pennsylvania Statewide PDL or AmeriHealth Caritas Pennsylvania Supplemental Formulary. Medication may be approved on an as needed basis for patients requiring replacement medication or for treatment of episodic bleeding. Delivery of approved products to Members is coordinated via authorized Specialty Pharmacy Providers.

Bleeding Disorder Program Contact: **PerformRxBleedingDisorders@performrx.com**

Generic Medications

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

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

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

Over-the-Counter Medication

Certain generic over-the-counter medications* are covered by the Plan with a prescription from the prescribing Health Care Provider. These may include:

- Analgesics such as aspirin, acetaminophen and non-steroidal anti-inflammatory drugs
- Antacids
- Anti-diarrheals such as loperamide and kaolin-pectin combinations
- Anti-flatulents such as simethicone
- Antihistamines
- Antinauseants
- Bronchodilators

- Cough and cold preparations (members older than 2 years of age)
- Contraceptives
- Hematinics not including long-acting products
- Insulin
- Laxatives and stool softeners
- Nasal preparations
- Ophthalmic preparations
- Single and multiple ingredients topical products such as antibacterials, anesthetics, anti-fungals, dermatological baths, rectal preparations, tar preparations (excluding soaps, shampoos, and cleansing agents), wet dressings, scabicides, corticosteroids (such as hydrocortisone 1% for rashes), and benzoyl peroxide.
- Single and multiple vitamins with and without fluoride
- Oral electrolyte mixtures
- Some prenatal vitamins
- Tobacco cessation products
- Vitamins and minerals

*Covered over-the-counter medications can be found within the online formulary at **www.amerihealthcaritaspa.com** → **Pharmacy → Formulary → Searchable Formulary**.

Diabetic Testing Supplies

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

- Blood glucose monitors are covered with a prescription for Plan Members with diabetes. Members are eligible for 1 blood glucose monitor per 365 days.
- Meters, strips, lancets and control solution may be prescribed for members with diabetes and filled at all participating network pharmacies.
- Please refer to the Pennsylvania Department of Human Services Statewide Preferred Drug List (PDL) for the current preferred products and quantity limits.

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

Non-Covered Medications

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

- Drugs for hair growth or other cosmetic purposes
- Drugs that promote fertility
- Non-legend drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes and similar items with the exception of products for tobacco cessation

- Pharmaceutical services provided to a hospitalized person
- Drugs and devices classified as experimental by the FDA or not approved by the FDA
- Placebos
- Non-legend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, and other personal care and medicine chest items
- Non-legend aqueous saline solution
- Non-legend water preparations
- Non-legend drugs not covered by the MA Program
- Items prescribed or ordered by a Health Care Provider who has been barred or suspended from participating in the MA Program
- DESI drugs and identical, similar or related products or combinations of these products
- Legend or non-legend drugs when the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted because of improper utilization or abuse
- Non-legend impregnated gauze and any identical, similar, or related non-legend products
- Any pharmaceutical product marketed by a drug company which has not entered into a rebate agreement with the Federal Government as provided under Section 4401 of the Omnibus Reconciliation Act of 1990
- Drugs prescribed for the treatment of Sexual or Erectile Dysfunction (ED)

Additional Resources Online

The Plans have dedicated Opioid Treatment resource web pages that provide information and resources including state, local and plan resources. Visit the sites at:
http://www.amerihealthcaritaspa.com/pharmacy/index.aspx

For behavioral health and substance use disorders resources, including information about Centers of Excellence and resources for pregnant members with substance use disorders, please refer to our website at **https://www.amerihealthcaritaspa.com/provider/initiatives/opioid.aspx**

Podiatry Services/Orthotics

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

Preventable Serious Adverse Events Payment Policy

The Patient Protections and Affordable Care Act of 2010 (ACA) defines Provider Preventable Conditions (PPC) to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is AmeriHealth Caritas Pennsylvania's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An

HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of

Medicare's hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

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

Submitting Claims Involving a PPC

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

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

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

Practitioner/Dental Providers

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

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

Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D of the CMS 1500 claim form.
- Dental Providers must report a PPC on the paper ADA claim form using modifier PA, PB or PC on the claim line, or report modifiers PA, PB or PC in the remarks section or claim note of a dental claim form.

Claim Format:

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

Inpatient/Outpatient Facilities

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

For Inpatient Facilities

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

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

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

Medical Claim Review
AmeriHealth Caritas Pennsylvania PO Box 7304
London, KY 40742

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

For Outpatient Providers

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

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52; and
- Surgery on wrong site Y65.53.

Reporting a Present on Admission PPC

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

Valid POA indicators are as follows:

- "Y" = Yes = present at the time of inpatient admission "N" = No = not present at the time of inpatient admission.
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission.
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not.
- "Null" = Exempt from POA reporting.

Recipient Restriction Program

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

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

- Member fills prescriptions at >2 pharmacy locations monthly for at least 3 months.
- Member has prescriptions written by ≥2 prescribers monthly for at least 3 months.
- Member fills prescriptions for ≥ than 2 controlled substances monthly for at least 3 months.

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

Additional Examples of Fraud, Waste and Abuse

Recipient Fraud: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND 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 Pennsylvania EBT ACCESS/**MCO** card, **forging or altering prescriptions, selling prescriptions/medications**, trafficking SNAP benefits or taking advantage of the system in any way.

Provider Fraud: 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; up-coding 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.

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

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

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

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

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

For more information concerning the Recipient Restriction Program, please refer to applicable Medical Assistance regulations (55 Pa. Code § 1101.91 and § 1101.92) located in Section 12 of this Manual.

Radiology Services

The following services, when performed as an outpatient service, require prior authorization by the Plan's radiology benefits vendor, Evolent Specialty Services, Inc. (Evolent).

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

To request prior authorization contact the Plan's radiology benefits vendor (Evolent via their provider web-portal at www1.radmd.com or by calling Evolent Phone Number for AmeriHealth Caritas Pennsylvania at 1-800-424-5657 Monday through Friday 8 a.m. – 8 p.m. (EST).

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

Weekend, Holidays and After-Hours Requests*

Requests can be submitted online at **www.radmd.com**- the Evolent web site is available 24 hours a day to providers.

Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to Evolent and a message may be left at **1-800-424-5657**, which will be retrieved the following business day, which will be retrieved the following business day.

Requests left on voice mail:

- Evolent will contact the requesting Provider's office within one business day of receipt of the voice mail request to obtain necessary demographic and clinical information to process the request.

*** Evolent's hours are 8:00 a.m. – 8:00 p.m. Eastern Time, Monday through Friday, excluding holidays**

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

Rehabilitation

If a Member requires extended care in a non-hospital facility for rehabilitation purposes, the Plan's Utilization Management Department will provide assistance by coordinating the appropriate placement, thus ensuring receipt of Medically Necessary care. A Utilization Management Coordinator will conduct Concurrent and Retrospective Reviews for all inpatient rehabilitation cases. AmeriHealth Caritas Pennsylvania's Utilization Management Department may be reached at **1-800-521-6622.**

Reporting Communicable and Noncommunicable Diseases

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

Termination of Pregnancy

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

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

Life Threat

When termination of pregnancy is necessary to avert a threat to the Member's life, a physician must certify it in writing and document in the Member's record that the life of the Member would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the Member's life is endangered is a medical judgment to be made by the Member's physician. This certification must be made on the **Pennsylvania Department of Human Services' Physician's Certification for an Abortion** (MA 3 form) (see Appendix for sample). The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by the Plan. If the Member is under the age of 18, a Recipient Statement Form (MA368) must be completed and submitted.

Rape or Incest

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

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

Vision Care

Vision Benefit Administrator

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

These inquiries should be directed to AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

Corrective Lenses for Children (Younger Than 21 Years of Age):

Members younger than 21 years of age are eligible for two routine eye examinations every calendar year, or more often if Medically Necessary. No referrals are needed for routine eye exams. Members are also eligible to receive two pairs of prescription eyeglasses, every 12 months, or more often if Medically Necessary. Prescription contact lenses may also be chosen for Members younger than 21 years of age.

If the prescription eyeglasses are lost, stolen or broken, the Plan will pay for them to be replaced, if approved. Please contact Davis Vision's Provider Relations Department at **1-800-773-2847** to obtain an approval. Lost, stolen or broken prescription contact lenses will be replaced with prescription eyeglasses.

- Members may choose from two select groups of eyeglass frames at no charge; or
- They may choose from a select group of premier eyeglass frames for a co-payment of
- $35.00; or
- They may choose eyeglass frames that are not part of the select groups and the Plan will pay a portion of the cost, up to $30.00, whichever is less.
- If prescription contact lenses are chosen, the Plan will pay for the cost of the prescription lenses or $60.00, whichever is less.

There are special provisions for Members with aphakia and cataracts. Please refer to "Eye Care Special Provisions" topic below.

Eye Care Benefits for Adults (21 Years of Age and Older):

These eye care special provisions are:

• If a Member has aphakia, he or she is eligible to receive two pairs of prescription eyeglasses or prescription contact lenses per year. The full cost of the prescription contact lenses will be covered at no cost.

• If the Member has cataracts, he or she may receive prescription eyeglasses.

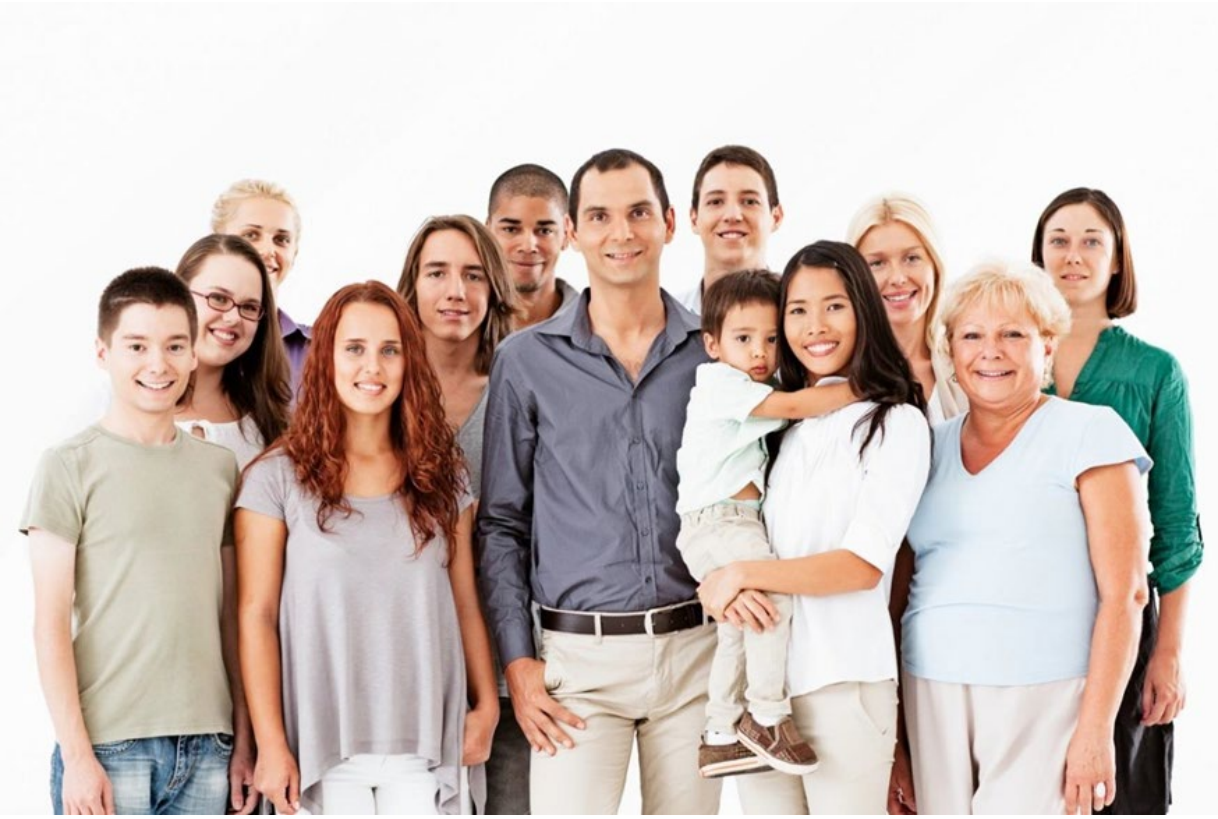
• If the Member has a diagnosis of diabetes (excluding gestational or pre-diabetes) he or she may receive frames and eyeglasses once every twelve months or in lieu of eyeglasses the cost of prescription contact lenses up to $75.00.

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

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

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

Section 3: Member Eligibility



Enrollment Process

AmeriHealth Caritas Pennsylvania is one of the health plans available to Medical Assistance (MA) recipients in DHS's HealthChoices program.

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

The Plan Identification Card

The Plan Identification Card lists the following information:

- Member's Name
- Identification Number
- Member's Sex and Date of Birth
- State ID Number
- PCP's Name and Phone Number*
- Lab Name
- Co-pays

To see the current Plan Identification Card template, please visit
www.amerihealthcaritaspa.com → Members → Information for You → ID Cards

*Some Plan Identification Cards may not have this information.

Continuing Care

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

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

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

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

- Any child (under the age of 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the Provider.

The Plan allows:

Newly Enrolled Members to receive ongoing treatment from a Health Care Provider who is not in the Plan Network for up to 60 days from the date the Member is enrolled in the Plan.

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

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

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

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

Ongoing treatment or services are reviewed on a case-by-case basis and include, but are not limited to: pre-service or follow-up care related to a procedure or service and/or services that are part of a current course of treatment. If a Member wants to continue treatment or services with a Health Care Provider who is not in the Plan Network: (1) the Health Care Provider must contact **AmeriHealth Caritas Pennsylvania's Utilization Management Department at 1-800-521-6622**; Or (2) the Member must contact **AmeriHealth Caritas Pennsylvania's Member Services Department at 1-888-991-7200.**

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

The Health Care Provider must receive approval from the Plan to continue care. The Plan will not cover continuing care with a Health Care Provider whose contract has ended due to quality of care issues or who is not compliant with regulatory requirements or contract requirements, or if the Provider is not a Medical Assistance Provider.

Verifying Eligibility

Each Network Provider is responsible to ascertain a Member's eligibility with the Plan before providing services. The plan Members can be eligible for benefits as follows*:

- Recipients who are determined eligible for coverage with an MCO between the 1st and 15th of the month will be enrolled with the MCO effective the 1st of the following month
- Recipients who are determined eligible for coverage with an MCO between the 16th and the end of the month will be effective with the MCO the 15th of the following month. Newborns and re-enrolled Members can be effective any day of the month, therefore, verification of eligibility is highly recommended prior to delivery of care
- Network Providers may not deny services to a Medical Assistance consumer during that consumer's Fee-For-Service eligibility window prior to the effective date of that consumer becoming enrolled in a Pennsylvania HealthChoices MCO.

*In some instances there may be a four-to-six week waiting period, known as the Fee-for-Service eligibility window, for the recipient to be effective with one of the MCOs, such as the Plan.

Verification of eligibility consists of a few simple steps; they are:

- As a first step, all Providers should ask to see the Member's Plan Identification Card and the Pennsylvania (PA) Electronic Benefits Transfer (EBT) ACCESS Card.
    - Providers should also ask the Member if they have any additional medical insurance coverage.
- It is important to note that the Plan ID cards are not dated and do not need to be returned to the plan should the Member lose eligibility. Therefore, a card itself does not indicate a person is currently enrolled with the Plan.

Since a card alone does not verify that a person is currently enrolled in the Plan, it is critical to verify eligibility each time services are provided through any of the following methods:

1. **PROMISe Provider Portal**
    a. Visit https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx
2. **Pennsylvania Eligibility Verification System (EVS): 1-800-766-5387**, 24 hours/7 days a week.
    a. If a Member presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA Electronic Benefits Transfer (EBT) ACCESS card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.
    b. The plastic "Pennsylvania EBT ACCESS Card" has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS.
3. **Internet**: NaviNet (**www.navinet.net**). This free, easy to use web-based application provides real- time current and past eligibility status and eliminates the need for phone calls to the Plan.

a. For more information or to sign up for access to NaviNet visit the Provider Center at **www.amerihealthcaritaspa.com** or **www.navinet.net** or call NaviNet Customer Service at **1-888-482-8057.**

4. **The Plan's Automated Eligibility Hotline**: AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007**: Provides immediate real-time eligibility status with no holding to speak to a representative.
   a. Verify a Member's coverage with the Plan by their Plan identification number, Social Security Number, name, birth date or Medical Assistance Identification Number.
   b. Obtain the name and phone number of the Member's PCP.

Monthly Panel List

Below is an example of the monthly panel list. The list is available on NaviNet at **www.navinet.net** The Member names below are for demonstration purposes only and do not represent actual Members/patients. It is important to check panel rosters routinely to review Members who are missing important services, such as pediatric EPSDT screenings and adult preventative care visits.

Note: All Members are assigned a PCP. Select services, e.g., EPSDT, that are provided for a Member not assigned to your panel, will be reimbursed at 100% of the Pennsylvania Medical Assistance fee schedule, rather than at your specific contract rates. All other services will not be paid. As a reminder, it is critical to check Member eligibility prior to the visit (please refer to the Member Eligibility section for the methods available).

Sample Panel List

All information on this sample is fictitious

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Member ID#	**Recipient#**	**DOB**	**Name**	**Address**	**Phone**	**Age**	**Gender**	**Other Ins**	**Date Eff On Panel**	**V***	**Provider Name/No**	**N***	**Restriction**	**Language**
11111111	1010101010	5/2/2002	Abdul, Abba	2323 Warren St Phila PA 19100	215-999-9999	3m	M		5/2/2002		J Brown 11223344	Y		English
53333333	4030303030	2/1/1975	Abdul, Geraldine	414 Narth Ave Phila, PA 19100	215-999-9999	27	F		2/1/2001		R Kelly 1156677			
37777777	6070707070	8/31/1986	Absent, Carol	8787 Cookie Ln Phila, PA	215-999-9999	15	F		6/1/2001		B Hamster 11777577			
84444444	7040404040	6/12/1990	Amber, Diane	3535 Creig St Phila, PA 19182	215-999-9999	49	M	Y	1/1/2000	Y	J Brown 1122334			
95555555	5050505050	10/5/1949	Bratt Esther	30 Wonder Rd Phila, PA 19181	215-777-7777	61	F	Y	7/1/1999		B Hamster 1122110	Y		
50000000	6060606060	3/16/1967	Download, Darren	55 Blank St Phila, PA	215-222-2222	58	M		3/1/1997	Y	M Weinbert 1177558			
62000000	3060606060	4/21/1996	Candy, Frank	251 Bleak Rd Phila, PA 19179	215-444-4444	6	F		8/12/02		J Brown 11223344	Y		

Panel Count = 7

1. Plan Identification Number

2. Member's Assistance Recipient Number
3. Member's date of Birth
4. Member's Name
5. Member's Address
6. Member's Phone Number
7. Member's Age
8. Member's Gender
9. Member's Other Insurance
10. Member's Effective Date with PCP
11. V* = Was Member Seen Within Last 6 Months
12. Member's Assigned PCP
13. N* = New Member to PCP
14. Indicates a Member restriction
15. Member's preferred language

Change in Recipient Coverage during an Inpatient Stay/Nursing Facility

The following policy addresses responsibility when there is a change in a recipient's coverage during an inpatient stay.

1. When a Medical Assistance (MA) recipient is admitted to a hospital under the Fee-For-Service (FFS) delivery system and assumes the Plan coverage while still in the hospital, the FFS delivery system is responsible for the inpatient hospital bill. On the effective date of the Plan coverage, the Plan is responsible for physician, Durable Medical Equipment (DME) and all other covered services not included in the inpatient hospital bill. If the MA recipient is transferred to another hospital after the Plan begin date, the FFS delivery system is responsible for the initial inpatient hospital bill from admission to discharge, and the Plan assumes responsibility for the subsequent hospital bill from point of admission to the hospital to which the MA recipient was transferred.
2. If MA recipient is covered by the Plan when admitted to a hospital and the recipient loses Plan coverage and assumes FFS coverage while still in the hospital, the Plan is responsible for the stay with the following exceptions:
    a. If the recipient is still in the hospital on the FFS coverage begin date, and the recipient's FFS coverage begin date is the first day of the month, the Plan is financially responsible for the stay through the last day of that month.
    b. If the recipient is still in the hospital on the FFS coverage begin date, and the recipient's FFS coverage begin date is any day other than the first day of the month, the Plan is financially responsible for the stay through the last day of the following month.

Starting with the FFS effective date, the FFS delivery system is responsible for physician, DME, and other bills not included in the hospital bill.

Exceptions:

a. The FFS program is financially responsible for the stay beginning on the first day of the next month.
b. The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

3. When a recipient is covered by an MCO when admitted to a hospital and transfers to another MCO while still in the hospital, the losing MCO is responsible for that stay with the following exceptions. Starting with the gaining MCO's begin date, the gaining MCO is responsible for the physician, DME, and all other covered services not included in the hospital bill.
    a. If the recipient is still in the hospital on the gaining MCO coverage begin date, and the recipient's gaining MCO coverage begin date is the first day of the month, the losing MCO is financially responsible for the stay through the last day of the month. The gaining MCO is financially responsible for the stay beginning on the first day of the next month.
    b. If the recipient is still in the hospital on the gaining MCO coverage begin date, and the recipient's gaining MCO coverage begin date is any day other than the first day of the month, the losing MCO is financially responsible for the stay through the last day of the following month. The gaining MCO is financially responsible for the stay beginning on the first day of the month after the losing MCO's responsibility ends.
4. If a Plan Member loses MA eligibility while in an inpatient/residential facility, and is never determined retroactively eligible, the Plan is only responsible to cover the Member through the end of the month in which MA eligibility ended.
5. **Recipient who is covered by the Plan when admitted to a hospital loses Plan and assumes Community HealthChoices (CHC)-MCO while still in the hospital**. The Plan is responsible for the hospital stay with the following exceptions. Starting with the gaining CHC-MCO's coverage begin date, the gaining CHC-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill.

EXCEPTION #1: If the Member is still in the hospital on the gaining CHC-MCO coverage begin date, and the Members's gaining CHC-MCO coverage begin date is the first (1st) day of the month, The Plan is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month.

Example:

If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The Plan remains financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the Recipient's gaining CHC-MCO coverage begin date is any day other than the first day of the month, the Plan is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.

Example:

If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The Plan remains financially responsible for the stay through August 31.

6. Recipient who is covered by CHC-MCO when admitted to a hospital loses CHC-MCO and assumes the Plan while still in the hospital. The losing CHC-MCO is responsible for the hospital stay with the following exceptions. Starting with the Plan's coverage start date, the Plan is responsible for the physician, DME and all other Covered Services not included in the hospital bill.

EXCEPTION #1: If the Recipient is still in the hospital on the Plan's coverage begin date, and the Recipient's Plan coverage begin date is the first (1st) day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the month. The Plan is financially responsible for the stay beginning on the first day of the next month.

Example:

If a Recipient is admitted to a hospital on June 21 and the Plan coverage begin date is July 1, the Plan assumes payment responsibility for the stay on August 1. The losing CHC-MCO remains financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the hospital on the Plan's coverage begin date, and the Recipient's Plan coverage begin date is any day other than the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the following month. The Plan is financially responsible for the stay beginning on the first day of the month following the next month.

Example:

If a Recipient is admitted to a hospital on June 21 and the Plan's coverage begin date is July 15, the Plan assumes payment responsibility for the stay on September 1. The losing CHC-MCO remains financially responsible for the stay through August 31.

Nursing Facilities

MA Provider Type/Specialty Type 03/31 (County Nursing Facility), 03/30 (Nursing Facility), 03/382 (Hospital Based Nursing Facility), and 03/040 (Certified Rehab Facility) or Medicare certified Nursing Facility:

The Department of Human Services (DHS) recently released Medical Assistance (MA) Bulletin 03-18-20 with the following clarifications for beneficiaries in HealthChoices (HC) zones where Community HealthChoices (CHC) has been implemented:

- Physical Health Managed Care Organizations (PH-MCOs) beneficiaries who are in PH-MCO nursing facilities are no longer disenrolled from their PH-MCO after receiving thirty (30) days of continuous nursing facility services.
- Beneficiaries receiving nursing facility services in a CHC zone will remain covered in their PH-MCO until they have been determined eligible for MA funded long-term services and supports, and enrollment in a CHC-MCO is indicated in the Eligibility Verification System (EVS).
- The period of extended PH-MCO coverage is referred to as the CHC Eligibility Determination Period.

Therefore:

- Residence in a nursing facility is not cause for disenrollment from the Plan.
- The Plan is responsible for nursing facility services so long as the Member is enrolled in the Plan. Once the Plan is notified that a Member has been determined Nursing Facility Clinically Eligible (NFCE), despite not being enrolled in CHC at the time, the Plan would continue to be responsible to provide nursing facility benefits and all other covered health benefits from the thirty-first (31st) day forward. For days from the 31st day forward, the Utilization Management department (UM) will review skilled nursing facility (SNF) admissions based on medical necessity review for the SNF level of care from the admission date through the discharge date or if there is a medical necessity denial from a Medical Director, whichever is sooner.
- If eCIS provides a CHC start date and if the Plan's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the same month, the last day of the Plan's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date.

Retroactive Eligibility

Occasionally, an MCO such the Plan may be responsible for retroactive care. For example, the Plan, as a Medical Assistance MCO, is responsible for a newborn from their date of birth when the mother is an active Member with the Plan on the newborn's date of birth. A newborn will have the same managed care history as the mother from birth until added to the Medical Assistance (MA) computer database.

The Plan is not responsible for retroactive coverage for a Member who lost MA eligibility but then regained it within the next six months. The Plan will commence coverage for the former Member on the MA re-Enrollment date or the date the recipient is updated in the MA computer data base, whichever is later.

- Example: A Plan Member loses MA eligibility on February 20th. The Plan is responsible to continue coverage until the last calendar day of the month (February 28th). If the recipient is determined to be MA eligible June 2nd, for retroactive coverage back to April 10th, and the MA computer database is updated on June 2nd, the Plan will resume responsibility for the Member June 2nd.

Eligibility for Institutionalized Members

The Plan covers the full scope of covered medical services to Members residing in the following:

- Private Intermediate Care Facilities for the Intellectually Disabled (ICF/ID/ORCs)
- Residential Treatment Facilities (RTF) within in the South East HealthChoices Zone
- Extended Acute Psychiatric Facilities
- Home and Community Based Waiver Program eligibles for Attendant Care Services (OSP/AC)
- Community Based Services Waiver Program (2176 Waiver)

Incarcerated Member Eligibility

The Plan is not responsible for any Member who has been incarcerated in a penal facility, correctional institution (including work release), or Youth Development Center. The Member will be disenrolled from the Plan effective the day before placement in the institution.

Providers should contact AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** upon identification of any incarcerated Member.

Pennsylvania Electronic Benefits Transfer ACCESS Card

Individuals eligible for benefits from DHS are issued a Pennsylvania Electronic Benefits Transfer (EBT) ACCESS Card ("EBT ACCESS Card"). The recipient uses the EBT ACCESS Card to obtain benefits such as food stamps, subsidized housing, medical care, transportation, etc.

Medical Assistance eligible persons are enrolled in a HealthChoices MCO to receive health benefits. The MCO issues an identification card so the Member can access medical benefits. The recipient uses the EBT ACCESS Card to "access" all other DHS benefits.

The plastic EBT ACCESS Card has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through the Eligibility Verification System (EVS). The Medical Assistance recipient's current eligibility status and verification of which MCO they may be

participating with can be obtained by either swiping the EBT ACCESS Card or by calling the EVS phone number **1-800-766-5387.**

If a Member presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have an EBT ACCESS Card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.

EVS Phone Number 1-800-766-5387

Treating Fee-for Service MA Recipients

Although the Plan operates and serves Members within the Department of Human Services'(DHS's) mandatory HealthChoices zones certain Medical Assistance (MA) recipients are eligible to access healthcare services through DHS's Fee-for-Service (FFS) delivery system.

DHS's goal is to ensure access to healthcare services to all eligible MA recipients. In some instances there may be a four-to-six week waiting period, known as the FFS eligibility window, for the recipient to be effective with one of the PH-MCOs.

Below are exceptions where eligible MA recipients would access healthcare services under the FFS delivery system, even if they reside in a mandatory HealthChoices zone:

- Newly eligible MA recipients while they are awaiting Enrollment into a MCO
- MA recipients with Medicare "A" & "B" coverage, known as "dual-eligibles", who are 21 years of age or older. MA recipients placed in a nursing home beyond 30 days
- MA recipients enrolled in the Pennsylvania Department of Aging (PDA) Waiver beyond 30 consecutive days
- MA recipients who have a change in eligibility status to a recipient group that is exempt from participating in HealthChoices, effective the month following the month of the change
- MA recipients who have been admitted to a state-operated facility, i.e. Public Psychiatric Hospital, State Restoration Centers and Long Term Care Units located at State Mental Hospitals
- MA recipients admitted to State-owned and operated Intermediate Care Facilities for the Intellectually Disabled (ICF/MR) and privately operated Intermediate Care Facilities for Other Related Conditions (ICF/ORC)
- MA recipients enrolled in the Health Insurance Premium Payment (HIPP) Program
- MA recipients placed in a Juvenile Detention Center (JDC) who are initially determined MA eligible during JDC placement; and those MA eligible recipients who are enrolled in a HealthChoices MCO who remain in a JDC beyond 35 consecutive days
- State-funded General Assistance MA recipients who are eligible for medical employability assessment only. These individuals are in the TD/55 category
- MA recipients who are enrolled in the State Blind Pension (SBP) program

Eligible MA recipients meeting one or more of the above exceptions may access healthcare services from any Health Care Provider participating in the Medical Assistance Program by presenting their DHS-issued EBT ACCESS Card. Simply verify the recipient's eligibility via DHS's website, **https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx**, or the Eligibility Verification System (EVS) at **1-800- 766-5387.**

Loss of Benefits

A Member can be disenrolled from the Plan if:

- The Member is no longer on Medical Assistance. (The Member should have been notified in writing that his/her case is closed. If the Member's case re-opens in less than six months, the Member will be automatically re-enrolled into the Plan).
- The Member moves to another part of the state. The Member should go to the County Assistance Office to see if he/she is still eligible for Medical Assistance.
- The Member moves out of Pennsylvania. The Member must find out about Medicaid in the new state of residence.
- The Member is admitted to a nursing facility outside the state of Pennsylvania.
- The Member is convicted of a crime and is in jail or a youth development center.
- The Member commits medical fraud or intentional misconduct and all appeals to DHS have been completed.

DHS may have to disenroll a Member from the Plan. The Member will receive health care coverage through DHS's Fee-for-Service program if:

- The Member is admitted to a Juvenile Detention Center for more than thirty-five (35) days in a row. The Member may re-enroll with the Plan after leaving the Detention Center.

Members who do not agree with the loss of health coverage must follow the Complaint or Grievance Procedures as outlined in the Member Handbook or in the Complaints, Grievance and Fair Hearings Procedures in Section 7 of this Manual.

Members may voluntarily disenroll from the Plan without giving specific reasons. To disenroll from the Plan, the Member must speak with an Enrollment Specialist by calling **1-800-440-3989 (TTY 1- 800-618-4225).**

Section 4: Provider Services

NaviNet

Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks – patient care. NaviNet is a "one-stop" service that supports your office's clinical, financial and administrative needs. If you are not already a NaviNet user, it is simple to start the process. Log on to **www.navinet.net** to register, or call **1-888-482-8057** to speak to NaviNet Customer Service.

NaviNet Supports Pre-Visit Functions

- **Eligibility and Benefits Inquiry**
  ✓ Access to Member eligibility and benefits
- **Care Gaps**
  ✓ A summary of the age/sex/condition appropriate health screens that a Member should have
  - **Care Gap Alerts***
    - Care Gap notification that appears when checking Member eligibility
    - View and print for Members coming in to your office. Place them with the patient's medical chart so they can be addressed during the visit.
  - **Care Gap Reports***
    - Customizable reports that can be used to target at risk Members
    - Can be downloaded and faxed back to the Plan with updated information

*Utilizing these tools to close gaps in care improves your opportunity for incentive dollars through the Plan's Pay-for-Performance Program.

- **Member Clinical Summary***

  ✓ A virtual snapshot of a patient's relevant clinical facts and demographic information in a user-friendly format. Member clinical summaries enable your practice to secure a more complete view of established patients and provide valuable information on new patients.

  ✓ The summary can be exported into EMR systems (CCD format). Member Clinical Summaries include the information such as:

  - Demographic information
  - Chronic conditions
  - ER Visits (within the past 6 months)
  - Observation stays
  - Inpatient Admissions (within the past 12 months)
  - Medications (within the past 6 months)
  - Office Visits (within the past 12 months)
  - Imaging Services
  - Lab Data

**Note: Your NaviNet Security Administrator will need to turn on access to this information for designated users in their NaviNet security profile, as this summary contains extensive personal health information.*

NaviNet Supports Patient/Provider Visits

- **Care Gaps (see Pre-Visit section above)**
  ✓ Use the care gap reports to provide your patients with appropriate and needed health screenings.
  ✓ Maximize your opportunity for incentive dollars.
- **Member Clinical Summary (see Pre-Visit section above)**

Prior Authorization Submission through Medical Authorizations via the Navinet Provider Portal. For detailed information, Frequently Asked Questions and training materials , visit AmeriHealth Caritas Pennsylvania Medical Assistance Plan Central on NaviNet.

- **Access Medical Authorizations, a streamlined online authorization workflow:**
  - Submit an Authorization
  - Submit an amended authorization
  - Verify if no authorization is required
  - Inquire on existing authorization
  - Attach supplemental documentation
  - Sign up for in-app status change notifications directly from the health plan
  - Access an authorization log
  - Medical Authorizations Video tutorials and user guide are available on the Navinet Plan Central Home Page

NaviNet Support Claims Management Functions

- NaviNet functionality allows your practice to:
  - Check the status of submitted claims
  - View claim EOBs
  - Perform claim investigations

NaviNet Supports Back Office Functions

- **Panel Roster**
  - Provides easy and immediate access.
  - Contains panel report plus historical reports for the past 12 months.
  - Reports can be imported into Excel for sorting and/or mailing to targeted patients.
  - Reports can be integrated with your practice management system.
- **Condition Optimization Program**

    - Identify Members with chronic and/or complex medical needs.
    - Assure chronically ill Members are routinely accessing Primary Care services.
    - Report complete and accurate diagnosis and disease acuity information.
    - Update the Plan on chronically ill patients and submit claims for reimbursement.
- Provider Directory Information Form
    - Provides easy and immediate access to change/update provider directory information

EDI Technical Support Hotline

The Plan has an EDI Technical Support Unit within the Information Solutions Department to handle the application, set-up and testing processes for electronic Claim submission. Please call the toll-free EDI Hotline at **1-877-234-4271** with any EDI inquiries, questions, and/or electronic billing concerns. More detailed information is available in the Claims Filing Instructions at **www.amerihealthcaritaspa.com**.

Some benefits of electronic billing include:

- Faster transaction time for Claims.
- Reduction in data entry errors on Claims processed.
- The ability to receive electronic reports showing receipt of Claims by the insurance plan.

AmeriHealth Caritas Pennsylvania's payer ID is 22248

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT simplifies the payment process by:

- Providing fast, easy and secure payments
- Reducing paper
- Eliminating checks lost in the mail
- Not requiring you to change your preferred banking partner

Enroll through our EFT partner, ECHO Health. For detailed information and instructions log on to **www.amerihealthcaritaspa.com** and click on **→ Providers → Billing → EDI-EFT-ERA Electronic Billing Services** or call **1-888-834-3511.**

ERA – Call ECHO Health customer service to sign up for electronic remittance advice at **1-888-471-3920.**

Provider Claims Service Unit

The Provider Claim Services Unit (PCSU) is a specialized unit of the Claims Department. This unit assists Providers with payment discrepancies and makes on-line adjustments to incorrectly processed Claims.

Some of the Claims-related services include:

- Review of Claim status (Note: Claim status inquiries can also be done online at **www.navinet.net**.)
- Research on authorization, eligibility and coordination of benefits (COB) issues related to Denied Claims
- Clarification of payment discrepancies
- Adjustment(s) to incorrectly processed Claims
- Assistance in reading remark, denial and adjustment codes from the Remittance Advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures
- Explanation of referral and authorization issues related to Claim payment
- Information on billing and Claim requirements
- Assistance in obtaining individual Network Provider numbers for Network Providers new to an existing Plan group practice

Call the Provider Claim Services Unit at **1-800-521-6007** as the first point of contact to resolve claims issues. For claims issues that can't be resolved through Provider Claims Services, contact your Provider Account Executive.

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider Network for Members. The staff is responsible for negotiating contracts with hospitals, physicians, ancillary, DME and other providers to assure our Network can treat the full range of Medical Assistance covered benefits in an accessible manner for our Members.

The primary contact for Network Providers with the Plan should be through Provider Services at **1-800-521-6007**. For any issues that cannot be resolved through standard operating departments, the provider's assigned Account Executive would be the appropriate contact. Provider Account Executives are responsible for orientation, continuing education, and diplomatic problem resolution for all Network Providers. The Account Executive will act as your liaison with the Plan.

The Account Executives visit Provider locations to conduct in-service/orientation meetings with Network Providers and their staff both pro-actively and in response to Network Provider issues involving policy and procedure, reimbursement, compliance, etc.

A complete list of Account Executive territory assignments and contact numbers is available at **www.amerihealthcaritaspa.com → Providers → Communications → Account Executives**

Provider Account Executives also perform an ADA site visit, practice environment evaluation and review medical record keeping practices of PCPs and OB/GYNs who are joining the network.

Provider Network Management will conduct a site visit and medical record keeping review for all PCP, OB/GYN, general and pediatric dentists applying to participate in the network. Scores for these reviews must be 85% or greater.

Provider Network Management, in collaboration with the Utilization Management Department, negotiates rates for non-participating Providers and facilities when services have been determined to be Medically Necessary and are approved by AmeriHealth Caritas Pennsylvania.

Contact your Account Executive to:

- Arrange for orientation or in-service meetings for Network Providers or staff
- Arrange for an appointment/dedicated time with your Account Executive
- To report any changes in your status, e.g.:
    - Phone number
    - Address
    - Tax I.D. Number
- Notify of additions/deletions of physicians affiliated with your practice
- Respond to any questions or concerns regarding your participation with AmeriHealth Caritas Pennsylvania

Network Providers are strongly encouraged to contact their Account Executive or Provider Services with changes to their demographic information. Network Providers may verify their demographic data at any time using the "real-time" Provider directory at **www.amerihealthcaritaspa.com → Providers → Provider Directory**

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices must be made on the Provider Change Form. These changes need to be submitted at least 30 days prior to the effective date of the change. The form is located in the Appendix of the Manual or can be found at **www.amerihealthcaritaspa.com → Providers → Resources → Forms → Provider Change**

The completed form and supporting documents can either be faxed to **1-717-651-1673** or mailed to:

AmeriHealth Caritas Pennsylvania
Provider Network Management
8040 Carlson Road, Suite 500
Harrisburg, PA 17112

Provider Services Department

The Plan's Provider Services Department operates in conjunction with the Provider Network Management Department, answering Network Provider concerns and offering assistance. Both departments make every attempt to ensure all Network Providers receive the highest level of service available.

The Provider Services Department can be reached twenty-four (24) hours a day, seven (7) days a week.

Call AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

- To ask about claims issues
- To ask questions about provider identification numbers
- To ask questions about notifications
- To verify Member eligibility/benefits
- To request forms or literature
- To ask policy and procedure questions
- To report Member non-compliance
- To obtain the name of your Provider Account Executive
- To request access to centralized services such as:
    - Outpatient laboratory services
    - Behavioral Health Services
    - Dental Services
    - Vision

Member Services

The Member Services Department helps our Members to understand and obtain the benefits available to them. Member Services Representatives are available twenty-four (24) hours a day, seven (7) days a week. Member Services Representatives also provide ongoing support and education to the Plan membership, focusing on communicating with our Members concerning their utilization of the Plan and managed care principles, policies and procedures. Call AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200 or TTY 1-888-987-5704**:

- Access on-call nurses after hours
- Assist Members looking for behavioral health information
- Identify non-compliant Members
- Help educate Members on how to access eligible benefits
- Get more information on Special Healthcare Needs, Disease Management, or ESPDT services
- Ask for health education materials in Member's preferred language and formats
- Help a Member choose or change a PCP or other Network Provider
- Request a list of Network Providers
- Learn what Members should do if a Health Care Provider sends a bill

Section 5: Primary Care Provider (PCP) & Specialist Office Standards & Requirements

Practitioner & Provider Responsibilities

Responsibilities of All Providers

- Be compliant with all applicable Federal and/or state regulations.
- Treat Plan Members in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., vaccines for children, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in Pennsylvania.
- Provide information to the plan and/or the Department of Human Services (DHS) as required.
- Inform Members about all treatment options, regardless of cost or whether such services are covered by the Plan. The Program Exception Process is when a Provider may request any service/product that is included in the Member's benefit package but not listed on the Medical Assistance fee schedule or services or equipment in excess of limitations set forth by the Department of Human Services fee schedule, benefit limits, and regulation. All requests for program exceptions require submission to the Utilization Management department for medical necessity review and prior authorization. For complete details on the prior authorization process, which includes requests for Program Exceptions, please refer to the Prior Authorization Requirements section of this manual.
- Provide patient medical records/charts as needed when a Member is seeking care from a specialist or changing primary care providers.
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for Members with Special Healthcare Needs such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer a Member or otherwise discriminate against a Member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the Member's Special Healthcare Needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept Plan payment or third party resource as payment-in-full for covered services.

- Comply fully with the Plan's Quality Improvement, Utilization Management, Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by the Plan, DHS and/or CMS.
- Promptly notify the Plan of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to the Plan or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and Health Information Technology for Economic and Clinical Health (HITECH) requirements.
- Immediately notify the Plan of adverse actions against license or accreditation status.
- Comply with all applicable Federal, State, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify the Plan of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- In the event of termination from the plan for any reason will fully cooperate in arranging for the transfer of copies of Member medical records to other Participating Providers.
- Verify Member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform Member(s) of the availability of the Plan's interpretive services and encourage the use of such services, as needed.
- Notify the Plan of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Plan Provider Agreement.
- Notify the Plan of any changes to the practice information in our directory that would impact a Member's access to care such as, telephone number, office hours, provider terminations, changes in location, etc. Maintain oversight of non-physician practitioners as mandated by State and Federal law.
- Agree that claims data, medical records, practitioner and provider performance data, and other sources of information, may be used by the Plan to measure and improve the health care delivery services to Members.
- Notice of nondiscrimination and the taglines must be posted in physical locations where providers interact with the public.
- Attending at least one Provider education training session conducted by the Plan.

PCP Role and Requirements

The PCP is the Member's starting point for access to all health care benefits and services available through the Plan. Although the PCP will certainly treat most of a Member's health care concerns in his or her own practice, the Plan expects that PCPs will refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.

All of the instructional materials provided to our Members stress that they should always seek the advice of their PCP before accessing medical care from any other source. It is imperative that the PCP and his or her staff foster this idea and develop a relationship with the Member, which will be conducive to continuity of care.

PCPs are required to contact:

- New Members who have not had an office visit within the first six (6) months of being on the PCP's panel;
- EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.
- Members who are not in compliance with EPSDT periodicity and immunization schedules; and
- Members who have not had an office visit during the previous twelve (12) months (See "Access Standards for PCPs" in this section of the Manual)

Additionally, PCPs are required to:

- Document reasons for non-compliance and the PCP's efforts to bring Member's care into compliance; and
- Identify any Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of notification by the Plan.

The Plan has the Let Us Know Program to assist practices in Member outreach and contact. See the program description in the Let Us Know section of the manual and complete program details on the Provider Center at **www.amerihealthcaritaspa.com**.

The PCP, or the designated back-up practitioner, should be accessible 24 hours per day, seven days per week, at the office site during all published office hours, and by answering service after hours.

When the PCP uses an answering service or answering machine to intake calls after normal hours, the call must be answered within ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

Appointment scheduling should allow time for the unexpected urgent care visit. (See "Access Standards for PCPs" in this section of the Manual)

PCPs should perform routine health assessments as appropriate to a patient's age and sex, and maintain a complete individual Member medical record of all services provided to the Member by the PCP, as well as any specialty or referral services. PCPs treating Members up to age 18 must participate in the VFC (Vaccine for Children) program.

PCPs who have Members under the age of twenty-one (21) on their panel are responsible for conducting all EPSDT screens for those Members. A PCP who is unable to conduct the necessary EPSDT screens is responsible for arranging to have them conducted by another Plan Network Provider and ensure that all relevant medical information, including having the results of the EPSDT screens incorporated into the Member's medical record.

School-based health services sometimes play a pivotal role in ensuring that children receive the health care they need. PCPs are required, with the assistance of the Plan, to coordinate and/or integrate into the PCP's records any health care services provided by school-based health services. The Plan can help by coordinating services between Parent/Guardian, PCP and other practitioners/providers. Call our Rapid Response and Outreach Team at **1-800-684-5503.**

PCPs are required to provide examinations for Plan Members who are under investigation by the County Children and Youth System for suspected child abuse or neglect. Services must be performed in a timely manner.

Providers must be alert for the signs of potential or suspected child abuse, and as mandatory reporters under the Child Protective Services law know their legal responsibility to report such suspicions. To make a report call:

- Child Line – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

Additional resources addressing mandatory reporter requirements:

- The Juvenile Law Center of Philadelphia, Child Abuse and the Law: **http://www.jlc.org/resources/publications/child-abuse-and-law**
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**

The Plan's dedicated web page to child abuse prevention at AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**.

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

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

Abuse or neglect of Plan Members' age of 18-59 may be reported to Adult Protective Services by calling **1-800-490-8505**.

Additional resources may be found here:

https://www.pa.gov/agencies/dhs/report-abuse/adult-protective-services.html

PCPs must communicate effectively with Members by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Member. Services must be free of charge to the Member. Refer to the Cultural Responsiveness section of the manual for complete details.

Members have the right to access all information contained in the medical record unless access is restricted for medical reasons.

Completing Medical Forms

In accordance with DHS policy, if a medical examination or office visit is required to complete a form, then you may not charge Plan Members a fee for completion of the form. Payment for the medical examination or office visit includes payment for completion of forms.

However, you may charge Plan Members a reasonable fee for completion of forms if a medical examination or office visit is not required to complete the forms. Examples include forms for Driver Licenses, Camp and/or School applications, Working Papers, etc. You must provide Plan Members with advance written notice that a reasonable fee will be charged for completing forms in such instances. However, if a Plan Member states that it will be a financial hardship to pay the fee, you must waive the fee.

The following physical examinations and completion of related forms are not covered by the Plan:

- Federal Aviation Administration (Pilot's License)
- Return to work following work related injury (Worker's Compensation)

Vaccines for Children Program

PCPs treating Members up to age 18 must participate in the Vaccine for Children (VFC) Program. The VFC Program provides publicly purchased vaccines for children birth through 18 years of age who are:

- Medicaid enrolled (including Medicaid managed care plans)
- Uninsured (have no health insurance) or
- American Indian/Alaskan Native

To enroll in the VFC Program, or for other inquiries about the VFC Program such as:

- Program guidelines and requirements

- VFC forms and instructions for their use
- Information related to provider responsibilities
- The latest VFC Program news
- Instructions for enrolling in the VFC Program

Please call **1-888-6-IMMUNIZE (1-888-646-6864)** or write to the Department of Health's Division of Immunizations at:

Pennsylvania Department of Health
Bureau of Communicable Diseases
Room 1023
625 Forster Street Harrisburg, PA 17120
Toll Free: **1-888-646-6864**
Telephone: **717-783-0479**
Email: **RA-pavfc@pa.gov**

PCP Reimbursement

PCP Fee-For-Service Reimbursement

Fee-for-service PCP reimbursement is a payment methodology used by the Plan. Practitioners are required to bill for all services performed in the primary care office. Reimbursement is in accordance with the Fee-for-Service Compensation schedule that is included in the Provider's contract.

Note: All Members are assigned a PCP. Select services, e.g., EPSDT, that are provided for a Member not assigned to your panel, will be reimbursed at 100% of the Pennsylvania Medical Assistance fee schedule, rather than at your specific contract rates. As a reminder, it is critical to check Member eligibility prior to the visit (please refer to the Member Eligibility section for the methods available).

Capitation/Above-Capitation Reimbursement

PCP capitation reimbursement is a monthly Capitation payment that is based on the age and gender of the Members assigned to their panels. When PCPs are contracted under this methodology and after monitoring monthly enrollment and disenrollment from each PCP's Member panel, the Plan issues to the PCP on or about the 15th of each month, a Capitation check and report on the amount of payment per Member. Capitated payment is considered reimbursement for services including all examinations, medical procedures and administrative procedures performed in the primary care office. Exceptions to the Capitation payment arrangement and services covered under such exceptions are determined on a case-by- case basis.

From time to time, the Plan implements pay for performance or other payment programs and will offer such programs to eligible Providers. To see the complete and detailed description of the Plan

PCP Incentive Program, please go to AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**

Member eligibility is determined on a daily basis. Capitation payments reflect the Member's effective date:

- For all Members enrolled with a first day of the month effective date, Capitation is paid at 100% of the rate appropriate for age and gender
- For all Members enrolled with an effective date after the first day of the month, Capitation is pro-rated. The pro-rated amount is determined by taking the full Capitation rate appropriate for age and gender then dividing it by the total number of days in the month. This per day amount is then multiplied by the number of days the Member is on the panel for that month
- Capitation payments are adjusted retroactively during the following month for any additional enrollment, which occurs during the last week of that month

This Capitation payment formula is also in effect for Members making PCP transfers, newborns and Member re-enrollments. The disenrollment policy is unaffected by this process. A three-month limit is applied to all retroactive adjustments made to primary care Capitation payments. This applies to Member enrollments, disenrollments and PCP panel transfers.

The Plan is responsible for reporting utilization data to DHS, on at least a monthly basis. It is therefore necessary that PCP Encounter information be received by the Plan on a regular basis. PCPs are required to submit an Encounter for every visit with a Member whether or not the Encounter contains a billable service. Additional information on Encounter reporting requirements can be found in the later part of this section. PCPs can earn additional compensation when the Plan is able to identify that they are treating medically complex Members.

To this end, it is important that all Encounters submitted contain all the diagnoses that have been confirmed by the PCP.

To see the complete and detailed description of the Plan's PCP Incentive Program, please go to please go to the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**.

Capitation Reimbursement Payment Method

Generally, PCP reimbursement is made using a Capitation method of payment (per Member per month assessment). The Plan will reimburse the PCP using the following age/sex breakdown.

Age/Sex Breakdown

From Age	To Age	Sex
0 yrs.	**< 1 yr.**	**M/F**

1 yr.	**< 2 yrs.**	**M/F**
> 2 yrs.	**< 4 yrs.**	**M/F**
5 yrs.	**14 yrs.**	**M/F**
15 yrs.	**18 yrs.**	**F**
15 yrs.	**18 yrs.**	**M**
19 yrs.	**39 yrs.**	**F**
19 yrs.	**39 yrs.**	**M**
40 yrs.	**64 yrs.**	**F**
40 yrs.	**64 yrs.**	**M**
65 yrs. & older		**M/F**

Legend: **<= less than** **M=Male** **Yr.(s)= Years of Age**
> = greater than **F=Female**

Procedures Compensated Under Capitation

- Capitated services include but are not limited to:
- Evaluation & Management Visits
- American Academy of Pediatrics recommended physical examinations of children and yearly physical examinations for adults
- Preventive Services
- Routine Gynecological Exam with PAP Smear
- EKG with Routine Interpretation
- Control of Nasal Hemorrhage
- Incision & Drainage of Abscesses
- Incision & Removal of Foreign Body, Subcutaneous Tissues
- Incision & Drainage of Hematoma
- Puncture Aspiration of Abscess, Hematoma, Bulla or Cyst
- Incision & Drainage of Complex Postoperative Wound Infection
- Initial Treatment of Burns
- Suture Removal
- Treatment of Sprains/Dislocations
- Routine Venipuncture
- Allergy Injections
- Anoscopy
- Occult Blood - Stool
- Audiometry/Tympanometry
- Urine Dip Stick

- Hemoglobin/Hematocrit
- Tuberculin Tests (Tine/PPD)
- Vision Screening
- Court Ordered Examinations and Tests
- Reasonable requests for the copying of Medical Records (e.g., for Specialists, change of Provider)

Procedures Reimbursed Above Capitation

In addition to Capitation, PCPs are routinely reimbursed on a Fee-for Service basis above Capitation for:

- Inpatient care (up to ten days)
- Attendance at high risk deliveries
- Inpatient newborn care
- Circumcisions of newborns
- Home visits
- Nursing home visits
- Immunizations as indicated on the Plan Procedures Reimbursed Above Capitation schedule

The PCP Office Visit

It is imperative that PCPs verify Member eligibility prior to rendering services to Plan Members. For complete instructions on looking up eligibility, please refer to the **"Member Eligibility"** Section of the Manual for additional information on verifying eligibility.

As a PCP, it is also necessary to complete and submit a CMS-1500 Form or an EDI Claim (electronic Claim submission) for each Member Encounter (each time a Member receives services, whether the service is capitated or billable above capitation). See "Encounter Reporting" in this section of the Manual for more information concerning Member Encounters.

Members must obtain a referral from their assigned PCP in order to access any Network Specialist. For further information on authorizations and referrals, see the "Referral Process" section of the Manual.

Forms/Materials Available

Plan-issued forms are available on the Provider Center at **www.amerihealthcaritaspa.com**, including but not limited to:

- Online provider directory
- Hospital notification of emergency admission
- Provider change form

- Let Us Know Member Intervention request form
- Obstetrical Needs Assessment form (ONAF)

Access Standards for PCPs

The Plan has established standards to assure accessibility of medical care services. The standards apply to PCPs. PCPs are expected to adhere to the following standards for appointment availability for medical care services, and other additional requirements.

Plan PCPs are expected to meet the following standards regarding appointment availability and response to Members:

Appointment Accessibility Standards

Appointment Accessibility Standards	
Medical Care:	**Plan Standard:**
Preventive Care must be scheduled *(health assessment/general physical examinations and first examinations)*	**Within 3 weeks of the Member's Enrollment**
Routine Primary Care must be scheduled	**Within 10 business days of the Member's call**
Urgent Medical Condition Care must be scheduled	**Within 24 hours of the Member's call**
Emergency Medical Condition Care must be seen	**Immediately upon the Member's call or referred to an emergency facility**

After-Hours Accessibility Standards	
Medical Care:	**Plan Standard:**
After-hours Care by a PCP or a covering PCP must be available *	**24 hours/7 days a week**

* When the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

The following are requirements for Members who require specific services and/or have Special Healthcare Needs. The Plan asks that PCPs contact all new panel Members for an initial appointment. The Plan has an Enhanced Member Supports Unit (EMSU)and a Care Management Program that also reach out to Members in the following categories. The Plan expects that PCPs will

cooperate in scheduling timely appointments. It is important for the PCP to inform the Plan if he/she learns that a Member is pregnant to assure appropriate follow up. Please call AmeriHealth Caritas Pennsylvania Bright Start Maternity Program at **1-877-364-6797** to refer a Member to the Bright Start Maternity Program and/or for assistance in locating an OB/GYN practitioner. (OB/GYN services do not require a referral.)

Initial Examination for Members…	**Appointment Scheduled with a PCP or Specialist**
with HIV/AIDS	**No later than 7 days of the effective date of Enrollment, unless the Member is already being treated by a PCP or Specialist.**
who receive Supplemental Security Income (SSI)	**No later than 45 days of Enrollment, unless the Member is already being treated by a PCP or a Specialist.**
under age of 21	**For an EPSDT screen no later than 45 days of the effective date of Enrollment, unless the Member is already being treated by a PCP or Specialist and the Member is current with screens and immunizations.**
Members who are pregnant	**Appointment Scheduled with an OB/GYN practitioner**
Pregnant women in their 1st trimester	**Within 10 business days of AmeriHealth Caritas Pennsylvania learning the Member is pregnant.**
Pregnant women in their 2nd trimester	**Within 5 business days of AmeriHealth Caritas Pennsylvania learning the Member is pregnant.**
Pregnant women in their 3rd trimester	**Within 4 business days of AmeriHealth Caritas Pennsylvania learning the Member is pregnant.**
High-risk Pregnant Women	**Within 24 hours of AmeriHealth Caritas Pennsylvania learning the Member is pregnant or immediately if an Emergency Medical Condition exists.**

Additional Requirements of PCPs

1. The average waiting time for scheduled appointments must be no more than 30 minutes unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour
2. Patients must be scheduled at the rate of six (6) patients or less per hour

3. The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments* and documented in the medical record
4. Number of regular office hours must be greater than or equal to 20 hours per week
5. Telephonic response time (call back) for non-emergency conditions should be less than two (2) hours
6. Telephonic response time (call back) for emergency conditions must be less than 30 minutes
7. Member medical records must be maintained in an area which is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including, obtaining any required written Member consents to disclose confidential medical records.
8. 24 hour/ 7 days per week coverage must be available via the PCP for Urgent and Emergency Medical Condition care. An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage. For example, it is not acceptable to have a message on an answering machine that instructs the Member to go to the emergency room for care without providing instructions on how to reach the PCP.
9. When the PCP is notified that the Member has visited the emergency room for either emergency or non-urgent issues, the PCP should contact the Member/Participant within 7-14 days to schedule a follow-up appointment. The PCP may also contact the Let Us Know program staff to request Member intervention and education.
10. PCPs must comply with all Cultural Responsiveness standards. Please refer to "PCP & Specialist Office Standards" in this Section of the Manual, as well as the "Regulatory Provisions" Section of the Manual for additional information on Cultural Responsiveness

* As a reminder, Medical Assistance providers are prohibited from billing Medical Assistance recipients for missed appointments, also known as "No Show". Please refer to Medical Assistance Bulletin 99-10-14 entitled "Missed Appointments" in the appendix of this manual.

11. When a PCP is notified that a Member is transferring or selecting a new PCP, the PCP should forward the Member's medical record to the new Primary Care network.

Please refer to "PCP & Specialist Office Standards" in this section of the Manual for further information on the following practitioner standards:

- Medical Record Standards
- Physical Office Layout

PCP Selection

Members are encouraged to select a Pediatrician/PCP for their newborn prior to receiving services. The Member can enroll their newborn with a PCP by calling AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200 or TTY 1-888-987-5704**. It is the PCP's

responsibility to contact the Provider Services Department prior to rendering services to a Member who has not yet selected a PCP.

Encounter Reporting

CMS defines an Encounter as "an interaction between an individual and the health care system." Encounters occur whenever a Plan Member is seen in a practitioner's office, whether the visit is for preventive health care services or for treatment due to illness or injury. An Encounter is any health care service provided to a Plan Member. Encounters, whether reimbursed through capitation, fee-for-service, or another method of compensation, must result in the creation and submission of an Encounter record (CMS-1500 form or electronic submission) to the Plan. The information provided on these records represents the Encounter data provided by the Plan to DHS.

Completion of Encounter Data

PCPs and Specialists must complete and submit a CMS-1500 form or file an electronic Claim every time a Plan Member receives services. Completion of the CMS-1500 form or electronic Claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services covered beyond capitation, including payment of inpatient newborn care and attendance at high risk deliveries
- It allows the Plan to gather statistical information regarding the medical services provided to Plan Members, which better support our statutory reporting requirements
- It allows the Plan to identify the severity of illnesses of our Members
- It allows the Plan to report HEDIS/Quality data to DHS

The plan can accept Encounter Claim submissions via paper or electronically (EDI). For more information on electronic Claim submission and how to become an electronic biller, please refer to the "EDI Technical Support Hotline" topic in Section 4 of the Manual or the Claims Filing Instructions in Section 6.

In order to support timely statutory reporting requirements, we encourage Providers to submit Encounter information within 30 days of the Encounter. However, all Encounters (Claims) must be submitted within 180 calendar days after the services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- Member’s Plan ID number
- Member's name
- Member's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOBs

- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM diagnosis codes, coded to the highest level of specificity.
- Authorization or referral number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT I and/or CPT II, procedure codes with appropriate modifiers
- Charges
- Days or units/NDC when applicable
- Physician/supplier federal tax identification number or Social Security Number
- National Practitioner ID (NPI) and Taxonomy Code
- Individual Plan assigned practitioner number
- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Please see "Claims Filing Instructions" in Section 6 of the Manual for additional information for the completion of the CMS form.

The Plan monitors Encounter Data submissions for accuracy, timeliness and completeness through Claims processing edits and through Network Provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network Providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to the Plan. Network Providers may be subject to sanctioning by the Plan for failure to submit 100% of Encounters, including Encounters for capitated services. Network Providers may also be subject to sanctioning by the Plan for failure to submit accurate Encounter data in a timely manner.

The Provider Services Department can address questions concerning Encounter Reporting by calling AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

Transfer of Non-Compliant Members

By PCP request, any Member whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel. The Plan's goal is to accomplish the uninterrupted transfer of care for a Member who cannot maintain an effective relationship with his/her PCP.

A written request on your letterhead asking for the removal of the Member from your panel must be sent to the Provider Services Department that includes the following:

- The Member's full name and Plan identification number
- The reason(s) for the requested transfer
- The requesting PCP's signature and Plan identification number

Transfers will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed emergency care.

The Provider Services Department will assign the Member to a new PCP and will notify both the Member and requesting PCP when the transfer is effective. Call AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007**.

Written requests should be faxed to the Panel Transfer Coordinator at **1-717-651-1673**.

Requesting a Freeze or Limitation of Your Member Panel

The Plan recognizes that a PCP will occasionally need to limit the volume of patients in his/her practice in the interest of delivering quality care. Each PCP office must accept at least 50 Members. Once a PCP has accepted the minimum number of Plan Members, a request may be forwarded to limit or stop assignment of Members to his/her panel.

The Plan must have 90 days advance written notice of any request to change panel status. For example, a panel limitation or freeze request received on May 1 would become effective on August 1. When requesting to have Members added to panels where age restriction or panel limitations exist, the Plan must be notified in writing on the PCP office's letterhead.

Policy Regarding PCP to Member Ratio

PCP sites may have up to 1,000 MA recipients (cumulative across all HealthChoices plans) per each full-time equivalent PCP at the site. For example, if a primary care site has seven full-time equivalent PCPs, they can have up to 7,000 MA recipients (cumulative across all HealthChoices plans).

Letter of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, PCPs may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a Network Provider or facility
- Initial documentation submitted is insufficient for the Plan to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Plan's Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff person managing the case of the Member in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Member's name and Plan identification number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Member
- Other treatment or testing methods, which have been tried but have not been successful along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure that is being requested

PCP Responsibilities under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both the "living will" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

PCPs should be aware of, and discuss, the Patient Self-Determination Act with their adult patients. Specific responsibilities of the PCP are:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not she/he has executed an advance directive
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives

The Plan provides our Members with information about the Patient Self-Determination Act via the Member Handbook. Excerpts from the Member Handbook regarding this topic can be found in Section 10 of the Manual entitled "Member Rights and Responsibilities."

Preventive Health Guidelines

The Preventive Health Guidelines were adopted from the U.S. Preventive Services Task Force. The contents of these guidelines were carefully reviewed and approved by peer providers at the Plan's Clinical Quality Improvement Committee. As with all guidelines, the Plan Preventive Health Guidelines are based on recommendations from the U.S. Preventive Services Task Force and are not intended to interfere with a Health Care Provider's professional judgment. The Preventive Health Guidelines are now available in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com** or you can call your Provider Account Executive to request hard copies.

Clinical Practice Guidelines

The Plan has adopted clinical practice guidelines for use in guiding the treatment of the Plan Members, with the goal of reducing unnecessary variations in care. The Plan clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The Plan's Clinical Practice Guidelines are available in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com** or call your Provider Account Executive to request a copy.

In support of the above guidelines, the Plan has Disease Management and Care Management programs available to assist you in the education and management of your patient with chronic diseases. For information, a copy of the above clinical guidelines, or to refer a Plan Member for Disease or Care Management Services, call AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** and ask for theEnhanced Member Supports Unit.

Specialty Care Providers

The Specialist Office Visit

The Plan Members receive Specialist services from Network Providers via a referral from their PCP's office. Specialist services are reimbursed on a fee-for-service basis at the Provider's contracted rate.

Prior to receiving Specialist services, Plan Members must obtain a referral from their assigned PCP. Prior to rendering services, Specialists should always verify Member eligibility, which can be done by checking "Member Eligibility" through the DHS EVS/Promise System or NaviNet online at **www.navinet.net** or by calling AmeriHealth Caritas Pennsylvania Provider Services at **1-800-521-6007**. For more information, please refer to "Referral & Authorization Requirements" in Section 2 of this Manual. Specialists should provide timely communication back to the Member's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care. It is necessary for all Network Providers to adhere to the applicable office standards as outlined in "PCP & Specialist Office Standards" in this Section.

Reimbursement/Fee-for-Service Payment

The Plan will reimburse all contracted specialists at fee-for-service rates described in the Network Provider's individual Plan Specialty Care Provider Agreement.

Please refer to "Claims Filing Instructions" in Section 6 of the Manual for complete billing instructions. Should you determine the need for diagnostic testing or procedures requiring authorization, please contact AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622** to obtain authorization.

Specialist Services

Specialists shall provide Medically Necessary covered services to Plan Members referred by the Member's PCP. These services include:

- Ambulatory care visits and office procedures
- Arrange or provide inpatient medical care at a Plan participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week

All Providers, particularly emergency, critical care and urgent care Providers, must be alert for the signs of potential or suspected child abuse, and as mandatory reporters under the Child Protective Services law, know their legal responsibility to report such suspicions. To make a report call:

- Child Line – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

Additional resources addressing mandatory reporter requirements:

- The Juvenile Law Center of Philadelphia, Child Abuse and the Law: **http://www.jlc.org/resources/publications/child-abuse-and-law**
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**
- The Plan's dedicated web page to child abuse prevention at **www.amerihealthcaritaspa.com → Providers → Initiatives → Child Sexual Abuse Prevention**.

Specialist Access & Appointment Standards

The average office waiting time should be no more than 30 minutes, or no more than one (1) hour when the Network Provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. Scheduling procedures should ensure:

- Emergency appointments immediately upon referral
- Urgent Care appointments within twenty-four (24) hours of referral
- Routine appointments within ten (10) business days of the referral
- Routine appointments within fifteen (15) business days of the referral for the following specialties: Otolaryngology, Dermatology, Dentist, Orthopedic Surgery, and the following Pediatric specialties: Endocrinology, General Surgery, Infectious Disease, Neurology, Pulmonology, Rheumatology, Allergy & Immunology, Gastroenterology, Hematology, Nephrology, Oncology, Rehab, Dentistry and Urology.

Network Providers must have a "no-show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record.

Payment in Full

As outlined in the Pennsylvania Department of Human Resources' Medical Assistance bulletin 99-99-06 entitled "Payment in Full", the Plan strongly reminds all providers of the following point from the bulletin:

Providers requiring Medicaid recipients to make cash payment for Medicaid covered services* or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania Medical Assistance program.

If a Medical Assistance participating Provider treats a dually eligible recipient and the Medicare payment (80% of the reasonable and customary charge) is equal to or greater than the Medical Assistance fee, the Provider has been "paid in full" and cannot seek reimbursement from the Medical Assistance recipient for the coinsurance or deductibles.

***Covered services include products, office visits, urine drug screens, counseling referrals, etc., used to treat opioid dependence.**

Additionally the Pennsylvania Code, 55 Pa. Code § 1101.63 (a) statement of policy regarding full reimbursement for covered services rendered specifically mandates that:

- All payments made to providers under the MA program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the provider for covered services rendered.
- A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

To review the complete MA Bulletin 99-99-06, "Payment in Full", visit the Provider Center at **www.amerihealthcaritaspa.com → Providers → Communications → DHS/Medical Assistance Bulletins**.

Confidentiality of Medical Records

Patient medical records must be maintained in an area that is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written Member consents to disclose confidential medical records. Please refer to "Medical Record Standards" in this section of the Manual for further information on the maintenance of medical records.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, Health Care Providers may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a Network Provider or facility
- Initial documentation submitted is insufficient for the Plan to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Medical Director or his/her designee.

Supporting medical documentation should be directed to the Clinical Service's staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Member's name and Plan ID number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Member
- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested

Specialist Responsibilities under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both "living wills" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

Specialists should be aware of and discuss the Patient Self-Determination Act with their adult patients. Specific responsibilities of the specialist are outlined below:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate.
- Document the discussion in the patient's medical record, and whether or not the patient has executed an advance directive.
- Provide the patient with written information concerning advance directives if asked.
- Do not discriminate against the individual based on whether or not he/she has executed an advance directive.
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives.

The Plan provides our Members with information about the Patient Self-Determination Act via the Member Handbook. Excerpts from the Member Handbook regarding this topic can be found in "Member Rights and Responsibilities" in Section 10 of the Manual.

Specialist as a PCP for Members with Special Healthcare Needs

Refer to the Special Healthcare Needs and Care Management Section for complete details.

Providers who are willing to serve/care for Members with Special Healthcare Needs should contact their Provider Account Executive.

PCP & OB/GYN Office Standards

Physical Environment

The Plan conducts an initial office site visit to all potential PCP and OB/GYN sites. Provider Network Management considers the results of the office site visit in making a determination as to whether the Health Care Provider will be approved for participation in the Plan's Network. The office site visit is intended to collect information about provider performance in the following areas:

- Facility Information
- Safety
- Provider Accessibility
- Treatment Areas
- General Information

The following are examples of standards that must be met for Plan network participation:

1. Office must have visible signage and must be handicapped-accessible*
2. Office hours must be posted
3. Office must be clean and presentable
4. Office must have a waiting room with chairs
5. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
6. Office must have at least two examination rooms that allow for patient privacy
7. Office must have the following equipment:
    a. Examination table
    b. Otoscope
    c. Ophthalmoscope
    d. Sphygmomanometer
    e. Thermometers
    f. Needle disposal system
    g. Accessible sink/hand washing facilities
    h. Bio-hazard disposal system
8. There must be a system in place to properly clean/decontaminate and sterilize reusable equipment. Bio-medical equipment must be part of an annual preventive maintenance program

9. Office must have properly equipped (handicapped-accessible) restroom facilities, readily accessible to patients
10. Patient records must be secured at all times, and not accessible to public areas
11. Must have written procedures for medical emergencies and a written evacuation plan During patient hours, at least one staff person must be CPR-certified
12. The office must be equipped with at least one fire extinguisher that is properly serviced and maintained
13. Must have blood-borne pathogen exposure control plan
14. Medications must be stored in a secure place away from public areas. Refrigerators used for medication storage must have a thermometer. Controlled substances must be locked, and prescription pads must be kept in a secure place

* Title III of the Americans with Disabilities Act (ADA, 42 U.S.C. 12101 et seq.) states that places of public accommodation must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as Health Care Providers) must specifically comply with, among other things, requirements related to effective physical accessibility, communication with people with hearing, vision, or speech disabilities, and other access requirements. For more information, you can go to the Department of Justice's ADA Home Page **https://www.ada.gov/index.html**.

Medical Record Standards

Complete and consistent documentation in patient medical records is an essential component of quality patient care. The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Compliance with the Plan's medical record standards and preventive health guidelines are evaluated, not less than every 2 years, based on a random selection process and/or as determined by the Plan for Primary Care Providers (PCP), Obstetrics and Gynecology (OB/GYN) provider, high-impact/high-volume specialists and other providers as deemed appropriate. Providers are notified of Plan medical standards through the Provider newsletter and website. PCPs and Specialists also receive a copy of the standards at the time of their initial and subsequent site visit.

The Plan performs an annual medical record review on a random selection of practitioners. The medical records are audited using these standards.

The following is a list of our standards (you can also find the standards online in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**).

- Medical records are organized in a consistent manner, and the records are kept secure, confidential, and only authorized staff have access
- Staff receive training on Member information confidentiality
- Patient's name or identification number is included on each page of record
- All entries are legible, initialed or signed and dated by the author
- Personal and biographical data are included in the record

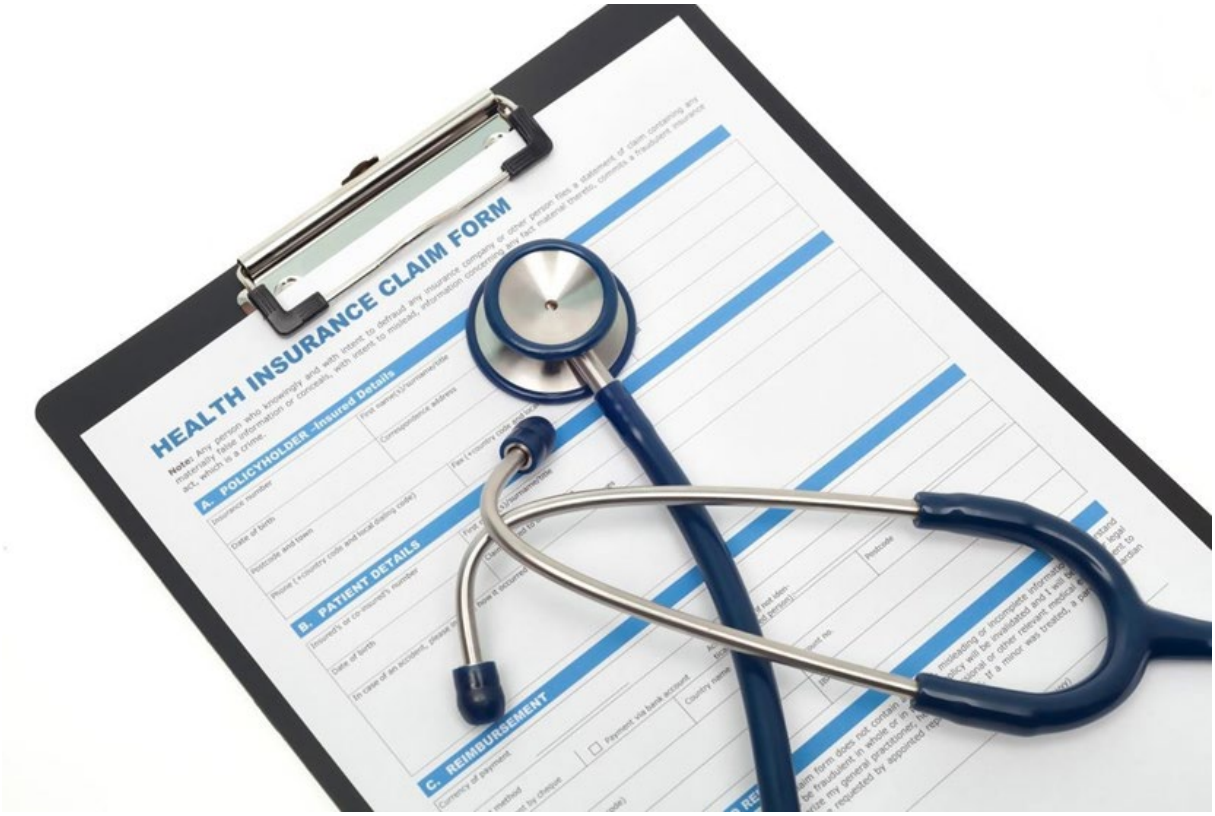
- All services are provided by a PCP or allied health professional under the supervision of a PCP Current and past medical history and age-appropriate physical exams are documented including serious accidents, operations and illnesses
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA"
- Information regarding personal habits such as smoking and history of alcohol use and substance use (or lack thereof) is recorded when pertinent to proposed care and/or risk screening
- An updated problem list is maintained
- Documentation of discussions of a living will or other advance directive for patients 65 years or older
- Patient's chief complaint or purpose for visit is clearly documented
- Clinical assessment and/or physical findings are recorded. Appropriate working diagnoses or medical impressions are recorded for each visit
- Plans of action/treatment are consistent with diagnosis
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure
- Unresolved problems from previous visits are addressed in subsequent visits
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the Network Provider and updated as needed
- Healthcare education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate
- Screening and preventive care practices are in accordance with the Plan Preventive Health Guidelines
- An immunization record is up to date (for Members under 21 years of age) or an appropriate history has been made in the medical record (for adults)
- Requests for consultations are consistent with clinical assessment/physical findings
- Laboratory and other studies are ordered, as appropriate
- Laboratory and diagnostic reports reflect Network Provider review
- Patient notification of laboratory and diagnostic test results and instruction regarding follow- up, when indicated, are documented
- There is evidence of continuity and coordination of care between PCPs and Specialists
- Practitioners are required to achieve a medical record score of 90% or greater to meet the Plan's MRR standards.
- Practitioners that do not achieve the score of 90% will have re-audit within 120 days to ensure that the deficiencies area corrected.
- Results for practitioners not achieving a passing score of 90% on the re-audit are presented to the Plan’s Credentialing Committee for review and recommendations. The Practitioner will be notified of the Committee's recommendations within ten (10) business days. The Plan’s Quality Management Department will provide oversight of

Committee's recommendations and any Correction Action Plan’s requested for specific practitioner practices.

Medical Record Retention Responsibilities

Medical records must be preserved and maintained for a minimum of ten (10) years from termination of the Health Care Provider’s agreement with Plan or as otherwise required by law or regulatory requirement. Medical records may be maintained in paper or electronic form; electronic medical records must be made available in paper form upon request. Medical records should be organized in a manner that allows for easy retrieval.

Section 6: Claims



Claims Filing Instructions

The Plan's Claims Filing Instructions can be found in the Appendix of the Manual or accessed online in the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com** → Providers → Billing → Claims Filing Instructions.

The Claims Filing Instructions contains current information and is periodically updated as needed. If you prefer a hard copy of the Claims Filing Instructions, please contact your Provider Account Executive or call AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007**.

National Provider Identification Number

The National Provider Identifier (NPI) is a Federally-issued 10-digit unique standard identification number that all Health Care Providers must use when submitting electronic claims.

Electronic claims submitted without an NPI will be rejected back to the provider via their EDI clearinghouse. Network Providers who submit claims via paper CMS 1500 or UB-04 are also required to include their NPI on their claims.

The Plan strongly encourages Network Providers to continue to submit claims with their Plan provider ID, in addition to the required NPI number.

How to Apply for Your NPI

Health Care Providers may apply for their NPI in one of the following ways:

- Complete the web-based application at **https://nppes.cms.hhs.gov**. This process takes approximately 20 minutes to complete.
- Call the Enumerator call center at **1-800-465-3203** or TTY **1-800-692-2326** to request a paper application.
- E-mail **customerservice@npienumerator.com** to request a paper application
- Request a paper application by mail:

NPI Enumerator
7125 Ambassador Road
Suite 100
Windsor Mill, MD 21244

NOTE: The most time-efficient method of getting an NPI is the web-based application process.

Additionally, Providers participating with the Plan must participate in the Pennsylvania Medical Assistance Program. Section 6401 of the Patient Protection and Affordable Care Act (P.L. 111-148) (ACA), as amended, requires that providers must be enrolled in Medicaid in order to be paid by Medicaid. This means providers must enroll and meet applicable Medical Assistance provider

requirements of DHS and receive a Pennsylvania Promise ID (PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

Important note: This does not apply to non-participating out-of-state providers under single case agreements.

DHS may make a determination that adopts the encounter limits or thresholds that would require the non-participating out-of-state providers to convert to in-network status, which would require enrollment in the Pennsylvania Medical Assistance Program.

Enroll by visiting: **https://www.pa.gov/services/dhs/enroll-as-a-medicaid-provider.html**

The Department of Human Services (DHS) also requires that Providers obtain an NPI and share it with them. Further information on DHS's requirements can be found at **https://www.dhs.pa.gov/providers/Providers/Pages/NPI.aspx**.

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

Prospective Claims Editing Policy

The Plan's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a Member's eligibility to receive covered health care services.

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to the Plan within 180 calendar days from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of **rejected Claims must occur within 180 calendar days** from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at AmeriHealth Caritas Pennsylvania at **www.amerihealthcaritaspa.com**.

Submission of Claims Involving Third Party Liability

If a Member has other insurance coverage in addition to the Plan coverage, the other insurance carrier (the "Primary Insurer") must consider the Health Care Provider's charges before the Claim is submitted to the Plan. Therefore, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. Claims with EOBs from Primary Insurers must be submitted within 60 days of the date of the Primary Insurer's EOB.

Please note – If a claim is paid and it is later discovered there was other insurance, the Plan will recover all reimbursement paid to the Provider.

Failure to Comply with Claim Filing Deadlines

The Plan will not grant exceptions to the Claim filing timeframes outlined in this section. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of the Plan's right to deny any future Claims that are filed after the deadlines or as a waiver of the Plan's right to retract payments for any Claims paid in error.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan. TPL does not affect the Member's Medicaid eligibility. Members may report other health care coverage (TPL) by calling Member Services at **1-888-991-7200 or TTY 1-888-987-5704**.

Coordination of Benefits (COB) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to the Plan. Therefore, before billing the Plan when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Members with Third Party Resources

Medicare as a Third Party Resource

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

In any event, the total combined payment made by Medicare and the Plan will not exceed the Plan contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

For Medicare physical health services that are not covered by the Plan or the MA Fee-For-Service Program, the Plan will pay cost-sharing amounts to the extent that the combined payment made under Medicare for the service and the payment made by the Plan do not exceed 80% of the Medicare approved amount.

The Plan's referral and authorization requirements are applicable if the services are covered by Medicare and the Member's Medicare benefits have been exhausted.

Commercial Third Party Resources

For services that have been rendered by a Network Provider, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health Care Providers must comply with all applicable Plan referral and authorization requirements.

Capitated Primary Care Providers (PCPs)

When services are rendered by a participating PCP or other capitated Network Provider, the Plan considers the coinsurance, deductible and/or co-payment to be a component of the Network Provider's Capitation payment and does not make a separate payment in addition to the Capitation.

Program Integrity

The Program Integrity Department is responsible for identifying and recovering claims overpayments for the Medicaid population which The Plan serves. The department performs several operational activities to ensure the accuracy of claim payments.

As a provider participating in The Plan's network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of The Plan's contract with the Pennsylvania Department of Human Services. Violations of these laws and regulations may be considered fraud or abuse against the Medical Assistance program. Some of the federal fraud and abuse laws physicians must be familiar with include the False Claims Act (31 U.S.C. §§3729-3733) ("FCA"), the Anti-Kickback Statute (42 U.S.C. §1320a-7b (b)), the Physician Self-Referral Law, also known as the Stark law (42 U.S.C. §1395nn), and the federal Exclusion Statute (42 U.S.C. §1320a-7).

The Plan is obligated to ensure the effective use and management of public resources in the delivery of services to its Members. The Plan does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and to the detection and prevention of fraud, waste, and abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of The Plan, regarding payments or the recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract, and with state and federal law. Examples of these Program Integrity initiatives include:

- Prospective (Pre-claims payment)
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical

Association ("AMA"), state regulatory agencies or The Plan medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
    - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that The Plan is only paying claims for Members where The Plan is responsible, i.e. where there is no other health insurance coverage.
    - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- Retrospective (Post-claims payment)
    - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, The Plan is by federal statute the payer of last resort. The effect of this rule is that The Plan may recover its payments if it is determined that a Member had other health insurance coverage at the time of the service.
    - Please also see Section 6 Claims for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, The Plan identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Record /Itemized Bill Review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. The scope of the validation may encompass any or all of the procedures, diagnosis or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
        - *Please note if medical records are not received within the requested timeframe, The Plan will recoup funds from the provider. Your failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the records.*
- Credit Balance Issues
    - Credit balance review service may be conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
    - Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you may be requested to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

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

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from providers causing overpayment
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility

The Claims Cost Containment Unit is also responsible for the manual review of provider initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

AmeriHealth Caritas Pennsylvania Claims Cost Containment
P.O. Box 7320
London, Kentucky 40742

Refunds for Claims Overpayments or Errors

The Plan and DHS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to adhere to the following requirements: In accordance with 42 U.S.C. §1320a-7k(d), in most cases, overpayments must be reported and returned to The Plan within sixty (60) days of identification. Section 6402(a) of the Affordable Care Act establishes that an overpayment retained beyond the timeframe established in 42 U.S.C. §1320a-7k(d) is an obligation per the federal False Claims Act ("FCA"). Providers who improperly retain an overpayment may be subject to liability, including penalties and damages, under the FCA.

1. Contact AmeriHealth Caritas Pennsylvania Provider Claim Services at **1-800-521-6007** to arrange the repayment. There are two ways to return overpayments to The Plan:

a. Have The Plan deduct the overpayment/improper payment amount from future claims payments, or
b. Return the overpayments directly to The Plan:
    i. Use the Provider Claim Refund form when submitting return payments to The Plan. A sample form can be found in the Appendix of the manual and is available on the Provider Center under Forms at **www.amerihealthcaritaspa.com**.
    ii. → Providers→ Resources → Forms→ Claim Refund form
    iii. Mail the completed form and refund check for the overpayment/improper payment amount to:
    iv. AmeriHealth Caritas Pennsylvania

ATTN: Claims Repayment Research Unit
P.O. Box 7118
London, KY 40742

Note: Please include the Member's name and ID, date of service, and Claim ID

2. Providers may follow the "Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol" to return improper payments or overpayments. Access the DHS voluntary protocol process via the following web address: **https://www.pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.html**

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

Special Investigations Unit

AmeriHealth Caritas Pennsylvania is a member of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas). AmeriHealth Caritas has an established enterprise- wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Our existing program has been developed in accordance with 42 CFR § 438.608, 42 CFR Part 455, the governing contracts between AmeriHealth Caritas Pennsylvania and the Commonwealth of Pennsylvania, and applicable federal and state laws. The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with the requirements as set forth in 42 C.F.R. Part 438, Subpart H (Certifications and Program Integrity) and 42 C.F.R. § 457.950(a)(2).

The Special Investigations Unit (SIU) is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claims payment processes for AmeriHealth Caritas Pennsylvania. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste and abuse.
- Takes corrective actions for any supported allegations after thorough investigation, including recovering overpayments that result from fraud, waste, or abuse.
- Reports confirmed misconduct to the appropriate parties and/or agencies.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the PH-MCO, a subcontractor, a Provider, or a Member, among others.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse– Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations for health care in a managed care setting. The Abuse can be committed by the Plan, Subcontractor, Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, the Plan, a Subcontractor, or Provider.

The annual mandatory Fraud, Waste, and Abuse Provider Training presentation can be found on our websites at: **www.amerihealthcaritaspa.com → Providers → Resources → Fraud, Waste, Abuse**.

After you have completed the training, please complete the attestation at **www.surveymonkey.com/r/FWAAttest.**

Recipient Fraud: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits and for example, that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

Provider Fraud: For example, billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; up-coding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of

service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

Fraud & Abuse – Summary of Relevant Laws and Examples

Under the HealthChoices program, The Plan receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from The Plan, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to **http://www.pacode.com/secure/data/055/partIIItoc.html** for more information regarding Fraud or abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

The Plan is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Sectionof the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services. As part of The Plan's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and/or abusive activities.

Bureau of Program Integrity Retrospective Review

The Department of Human Services, Bureau of Program Integrity (Department), is responsible for the retrospective monitoring and review of services for compliance with Medical Assistance (MA) regulations. As part of this monitoring process, a Physical Health Managed Care Organization's (PH-MCO) network provider's paid claims and the Department's encounters are validated and pertinent medical and/or financial records are reviewed to ensure payment was properly made by the MCO. See 55 Pa. Code §§ 1101.51(e) and 1101.71(a).

Rebuttals

Any provider rebuttal in relation to the Bureau of Program Integrity's (BPI) initiated Retrospective Review Process, are to be filed within the timeframes outlined within BPI's preliminary findings letter.

Provider Corrective Action Plan (PCAP)

As a result of the retrospective reviews that has been initiated by the Department of Human Services, Bureau of Program Integrity Division; the Plan must submit a Provider Corrective Action

Plan to the Department to resolve any Network Provider's regulatory violations as cited in the final findings notice from BPI.

At the conclusion of the retrospective review of a provider in which area(s) of noncompliance have been identified, the Department will issue a final findings letter that may require the submission of a PCAP to the Department.

Upon receiving confirmation from the Department of the required PCAP, the Plan's Provider Network Management team will work with the Provider to develop a corrective action plan that addresses the area(s) of noncompliance and all applicable federal and state regulations identified in the Department's final findings letter. The provider corrective action plan will reiterate program deficiencies, specify an efficient path toward overall improvement, monitor imposed changes (making adjustments as necessary) and advance accurate and expedient program delivery.

The Plan will send the PCAP to the Department for approval within sixty (60) calendar days of the Plan's receipt of the final findings letter.

- If approval is received from the Department the PCAP will be tracked and monitored for compliance for a period of at least (90) calendar days.
- If a denial is received from the Department with an indication of revision to the PCAP, the Plan's Provider Network Management team will work with the provider to address all of the Department's concerns. The revised PCAP will be submitted to the Department upon receipt.
- Once the Plan's Provider Network Management team has validated that all action items within the PCAP has been completed, the PCAP will be closed.

The Federal False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Penalties for violating the FCA include damages in the amount of up to three times the amount of the false claim plus civil penalties of $13,508 - $27,018 perfalse claim.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

The Federal Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA.

Among other things, FERA:

- Expands potential liability under the FCA for government contractors like AmeriHealth Caritas Pennsylvania
- Expands the definition of a false or fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like AmeriHealth Caritas Pennsylvania.
- Expands the definition of a false record to include any record that is material to a false or fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Pennsylvania has not yet enacted a false claims statute similar to the federal FCA. Pennsylvania does, however, have anti-fraud laws that impose criminal and civil penalties for false claims and false statements.

The Pennsylvania Fraud and Abuse Controls, 62 P.S. §§ 1407, 1408

This law, 62 P.S. § 1407, applies to Medicaid providers and prohibits the submission of false or fraudulent claims to Pennsylvania's Medical Assistance programs as well as the payment of kickbacks in connection with services paid in whole or in part by a Medical Assistance program. A violation of the law is a criminal felony offense that carries with it penalties of imprisonment of up to 7 years, fines, and mandatory exclusion from Pennsylvania's Medical Assistance programs for 5 years. In addition to criminal penalties, the law authorizes the Pennsylvania Department of Human Services to institute a civil action against a provider and seek as damages two times the amount of excess benefits or payments paid plus interest.

Pennsylvania has another anti-fraud law, 62 P.S. § 1408, that prohibits anyone from making false claims or false statements in connection with an application for Medical Assistance benefits or payments. Depending upon the nature of the violation, criminal penalties range from felony to misdemeanor offenses. In addition, the Pennsylvania Department of Human Services may institute a civil action against a person who violates this section and seek as damages the amount of the benefits obtained. The Pennsylvania Department of Human Services may also impose a penalty in the amount of $1,000 against any such person for each violation of the law.

The Pennsylvania Whistleblower Law, 43 P.S. §§ 1421 to 1428

The Pennsylvania Whistleblower Law provides protection from discrimination and retaliation to a person who witnesses or has evidence of wrongdoing or waste while employed and who makes a

good faith report of the wrongdoing or waste, verbally or in writing, to one of the person's superiors, to an agent of the employer, or to an appropriate authority.

No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer as defined in the act. In addition, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or in a court action. A person who, under color of an employer's authority, violates this act shall be liable for a civil fine of not more than $10,000.

In addition, a whistleblower that is retaliated against may bring an action in court and seek the following relief: reinstatement, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages, or any combination of these remedies. A court shall also award the whistleblower all or a portion of the costs of litigation, including reasonable attorney's fees, if the whistleblower prevails in the civil action.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement
- Misrepresentation of dates and times of service
- Misuse of Electronic Medical Records such as cloning and copying so records are identical not unique and specific as required.
- Failing to have supporting documentation for billed services
- Submitting multiple claims for the same services

Reporting and Preventing Fraud, Waste and Abuse (FWA)

If you, or any entity with which you contract to provide health care services on behalf of The Plan's beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact The Plan by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**;
- E-mailing to **FraudTip@amerihealthcaritas.com**; or,
- Mailing a written statement to **Special Investigations Unit, AmeriHealth Caritas, P. O. Box 7317, London, KY 40742**

Below are examples of information that will assist The Plan with an investigation:

- Contact Information (e.g. name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse directly to the Pennsylvania Department of Human Services through one of the following methods:

Phone:	**1-844-DHS-TIPS (1-844-347-8477), 1-866-379-8477(TTY)**
Online:	**http://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx**
	Form: **https://forms.dhs.pa.gov/dhs-ma-provider-compliance/**
Fax:	**1-717-772-4655**, Attn: MA Provider Compliance Hotline
Mail:	**Department of Human Services**
	Bureau of Program Integrity
	P.O. Box 2675
	Harrisburg, PA 17105-2675

What to Expect as a Result of SIU Activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from The Plan, or on behalf of The Plan, regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may also be contacted by the SIU Intake Unit to verify a complaint you filed.

- You may be contacted by an investigator in regards to a complaint they are investigating which may or may not concern you.
- As a provider you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your provider agreement, you are required to provide the records for review.

Provider agrees to cooperate with The Plan in maintaining and providing to The Plan or the Department, at no cost to them, medical records, financial data, administrative materials and other records related to services to Members as may be reasonably requested by The Plan and/or the Department.

After an investigation is completed there are a number of things that may occur such as a determination that the complaint was unfounded or a referral to: (1) the Bureau of Program Integrity for the Pennsylvania Department of Human Services, (2) the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section or (3) the federal Office of Inspector General for further investigation. You may receive an overpayment letter outlining what was found and if monies are owed. If you do not agree with the SIU findings in the Overpayment Letter, instructions are included describing how you can submit a dispute to the SIU. You could also receive and education letter outlining proper procedures that are to be followed for future reference. You could be placed on prepayment review.

Claim Disputes and Appeals

The Plan's goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials Rejected Claims

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Some examples are illegible Claim fields or missing or invalid codes and/or missing or invalid Member or Provider ID numbers. Rejected Claims are returned to the Health Care Provider or EDI source without registration in the Claim processing system. Since rejected Claims are not registered in the Claim processing system, the Health Care Provider must re-submit corrected Claims within 180 calendar days from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment

under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - within 180 days of date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information from the Health Care Provider is missing must be resubmitted for correction. Some examples are a missing Tax ID number, incomplete information or incorrect coding. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health Care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate "Corrected Claims" on the Claim form:

Corrected Claims/Adjusted Claims
AmeriHealth Caritas Pennsylvania
P.O. Box 7118 London, KY 40742

Resubmitted EDI Corrected Claims

Providers using electronic data interchange (EDI) can submit "professional" corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ Do include the plan's claim number in order to submit your claim with the 7
- ✓ Do use this indicator for claims that were previously processed (approved or denied)
- ✓ Do not use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ Do not submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at **1-866-695-1330** or **edi.support@amerihealthcaritas.com**
    - Providers using our NaviNet portal, (**www.navinet.net**) can view their corrected claims faster than available with paper submission processing.

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. **If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can call** AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** to report payment discrepancies. Representatives are available to review Claim information and make on- line adjustments to incorrectly processed Claims.

Emergency Room Payment Limitations

No payment will be made for Emergency Room services if:

- The Member is not eligible for benefits on the date of service
- The Member is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section 2 for notification requirements
- The service was provided outside of the United States or its territories.

If your Claim issues are not resolved following the steps outlined above, the procedures outlined in Section 7 may be followed. If the Network Provider disagrees with the Plan's Dispute decision, the Network Provider may file a Formal Provider Appeal.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365 day timeframe is exceeded.

Section 7: Provider Dispute/Appeal Procedures; Member Complaints, Grievances, and Fair Hearings

Provider Dispute/Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Plan department.

Informal Provider Disputes Process

Network Providers may request informal resolution of Disputes submitted to the Plan through its Informal Provider Dispute Process.

What is a Dispute?

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a Plan decision that directly impacts the Provider. Disputes are generally administrative in nature and do not include decisions concerning Medical Necessity. Disputes may focus on issues concerning the Plan services processes, other Health Care Provider, Members or claims.

Examples of Disputes include, but are not limited to:

- Service issues with the Plan, including failure to return a Network Provider's calls, frequency of site visits by the Provider Account Executives and lack of Provider Network orientation/education.
- Issues with the Plan's processes, including failure to notify Network Providers of policy changes, dissatisfaction with Prior Authorization process, dissatisfaction with referral process and dissatisfaction with Formal Provider Appeals Process.
- Contracting issues with the Plan, including dissatisfaction with the plan's reimbursement rate, incorrect capitation payments paid to the Network Provider and incorrect information regarding the Network Provider in Provider database.
- Claim payment disputes for non-authorization related denials (i.e. coordination of benefits denials)*

*Claim denials for authorization requirements not met may be appealed in accordance with the Plan's Formal Provider Appeals Process outlined later in this section.

Filing a Dispute

Network Providers wishing to register a Dispute should contact the AmeriHealth Caritas Pennsylvania's Provider Claims Services at **1-800-521-6007**, or submit the dispute through NaviNet. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

AmeriHealth Caritas Pennsylvania Informal Disputes
P.O. Box 7316
London, KY40742

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider Name

- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same issue, the Plan has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet and accompanying claims should be sent to the Providers assigned Account Executive. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet.**

The spreadsheet format can be found in Appendix or online in the Provider Center at **www.amerihealthcaritaspa.com**.

On-Site Meeting

Network Providers may request an on-site meeting with a Provider Account Executive, either at the Network Provider's office or at the Plan to discuss the Dispute. Depending on the nature of the Dispute, the Provider Account Executive may also request an on-site meeting with the Network Provider. The Network Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with the Plan. The Provider Account Executive assigned to the Network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Time Frame for Resolution

The Plan will investigate, conduct an on-site meeting with the Network Provider (if one was requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the Network Provider. The informal resolution of the Dispute will be communicated to the Network Provider by the same method of communication in which the Dispute was registered (e.g., if the Dispute is registered verbally, the informal resolution of the Dispute is verbally communicated to the Network Provider and if the Dispute is registered in writing, the informal resolution of the Dispute is communicated to the Network Provider in writing). If the informal resolution of the Dispute results in a claim adjustment, the Provider will receive a new explanation of benefits (EOB) for the claim(s) addressed in the dispute.

Relationship of Informal Provider Dispute Process to the Plan's Formal Provider Appeals Process

The purpose of the Informal Provider Dispute Process is to allow Network Providers and the Plan to resolve Disputes registered by Network Providers in an informal manner that allows Network

Providers to communicate their Dispute and provide clarification of the issues presented through an on-site meeting with the Plan. Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to the Plan's Formal Provider Appeals Process. The types of issues that may not be reviewed through the Plan Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this Manual. Appeals must be submitted in writing to the Plan's Provider Appeals Department. Procedures for filing an appeal through the Plan's Formal Provider Appeals Process, including the mailing address for filing an appeal, are set forth in the "Formal Provider Appeals Process" Section. The filing of a Dispute with the Plan's Informal Provider Dispute Process is not a prerequisite to filing an appeal through the Plan's Formal Provider Appeals Process.

In addition to the Informal Provider Dispute Process and the Formal Provider Appeals Process, Health Care Providers may, in certain instances, pursue a Member Complaint or Grievance appeal on behalf of a Member. A comprehensive description of the Plan's Member Complaint, Grievance and Fair Hearings Process is located in this Section of the Manual. Additionally, information on the relationship with the Plan's Informal Provider Dispute and Formal Provider Appeal Processes can be found in "Relationship of Provider Formal Appeals Process to Provider Initiated Member Appeals" and "Requirements for Grievances filed by Providers on Behalf of Members" in this Section of the Manual.

Formal Provider Appeals Process

Both Network and Non-Participating Providers may request formal resolution of an appeal through the Plan's Formal Provider Appeals Process. This process consists of two levels of review and is described in greater detail below.

What is an Appeal?

An appeal is a written request from a Health Care Provider for the reversal of a denial by the Plan, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through the Plan's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through the Plan's Informal Provider Dispute Process
- Post-service denials for services already rendered by the Health Care Provider to a Member including, denials that:
    - Do not clearly state the Health Care Provider is filing a Member Complaint or Grievance on behalf of a Member (even if the materials submitted with the Appeal contain a Member consent) or
    - Require medical necessity review- claim denials for authorization requirements not met.

Examples of appeals include, but are not limited to:

- The Health Care Provider submits a Claim for reimbursement for inpatient services provided at the acute level of care, but the Plan reimburses for a non-acute level of care because the Health Care Provider has not established medical necessity for an acute level of care.
- A Home Care Provider has made a total of ten (10) home care visits but only seven (7) visits were authorized by the Plan. The Home Care Provider submits a Claim for ten (10) visits and receives payment for seven (7) visits.
- Durable Medical Equipment (DME) that requires Prior Authorization by the Plan is issued to a Member without the Health Care Provider obtaining Prior Authorization from the Plan (e.g., bone stimulator). The Health Care Provider submits a Claim for reimbursement for the DME and it is denied by the Plan for lack of Prior Authorization.
- Member is admitted to the hospital as a result of an Emergency Room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital provider submits a Claim for reimbursement at the one-day acute inpatient rate but the Plan reimburses at the observation rate, in accordance with the hospital's contract with the Plan.
- The Health Care Provider submits a claim for reimbursement for a service that requires prior-authorization, however valid authorization was not obtained prior to the service being rendered.

Types of issues that may not be appealed through the Plan's Formal Provider Appeals Process are:

- Claims denied by the Plan because they were not filed within 180-day filing time limit; Claims from Network Providers denied for exceeding the 180-day filing time limit may be appealed through the Plan's Informal Provider Dispute Process outlined in this Manual.
- Pre-service denials issued as a result of a Prior Authorization review by the Plan (the review occurs prior to the Member being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the Member, or the Health Care Provider, with written consent of the Member, through the Plan's Member Complaint and Grievance Process outlined in the Section titled Complaints, Grievances and Fair Hearings for Members following the Provider Appeal Process.
- Health Care Provider terminations based on quality of care reasons may be appealed in accordance with the Plan Provider Sanctioning Policy outlined in Section 8; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section 8.
- Claim denials due to incorrect coding.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health Care Providers may request a First Level Appeal review by submitting the request in writing within sixty (60) calendar days of: (a) the date of the denial or adverse action by the Plan or the Member's discharge, whichever is later and (b) in the case where a Health Care Provider filed an

Informal Provider Dispute with the Plan, the date of the communication by the Plan of the informal resolution of the Dispute. The request must be accompanied by all relevant documentation the Health Care Provider would like the Plan to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the Post Office Box below:

Clinical Provider Appeals Department
AmeriHealth Caritas Pennsylvania
P.O. Box 7307 London, KY 40742

Physician Review of a First Level Appeal

The First Level Appeal Review is conducted by a board certified Physician employed by the Plan who was not involved in the decision making for the original denial or prior appeal review of the case. The Physician Reviewer will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Other available information including but not limited to:
    - Plan medical and administrative policies
    - Information submitted by the Health Care Provider or obtained by the Plan through investigation
    - The Network Provider's contract with the Plan
    - The Plan's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health Care Providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within sixty 60 calendar days of the Plan's receipt of the Health Care Provider's request for the First Level Appeal review. If the Health Care Provider is dissatisfied with the outcome of the First Level Appeal review, the Health Care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

In order to simplify resolution of Emergency Department payment level issues, which often arise because a claim was submitted without an Emergency Department summary and/or requires a review of medical records, participating hospital Providers are encouraged to address such payment issues through the Plan's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health Care Providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of the Plan's First Level Appeal determination letter.

The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the Health Care Provider would like the Plan to consider during the Second Level Appeal Review.

Requests for a Second Level Appeal Review of an Appeal should be mailed to the Post Office Box below:

Clinical Provider Appeals Department
AmeriHealth Caritas Pennsylvania
P.O. Box 7307 London, KY 40742

Appeals Panel Review of a Second Level Appeal

An external board-certified Physician, who is contracted but not employed by the Plan and was not involved in the decision-making for the original denial, or prior Appeal review of the case, will review the appeal. Within five (5) business days the Physician will issue a recommendation, including the clinical rationale, to the Plan's Appeals Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of the Plan's medical and administrative policies, available information submitted by the Health Care Provider or obtained by the Plan through investigation, the Health Care Provider's contract with the Plan, The Plan's contract with DHS and relevant Medicaid laws, regulations and rules.

Upon receipt of the external Physician's Second Level Appeal recommendation, a written summary of the Second Level Appeal recommendation is submitted to the Appeals Panel, which consists of at least 3 persons and includes 1/4 peer representation with members selected from the following:

- Physician who is employed by the Plan (peer representative).
- Senior Vice President of Provider Network Management or his/her designee;
- Director of Operations or his/her designee; and
- Manager of Appeals or his/her designee.

All supporting documentation submitted at the First Level Appeal review will be available along with the summary of the Appeal, the First Level Appeal outcome and all additional information submitted by the Health Care Provider at the time of the Second Level Appeal request will be presented to all members of the Appeals Panel in advance of and during the Appeals Panel meeting. The external Physician's recommendation is presented and the Appeals Panel makes the final decision during the Appeals Panel meeting.

The Appeals Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Other available information including but not limited to:
    - The Plan's medical and administrative policies
    - Information submitted by the Provider or obtained by the Plan through investigation
    - The Network Provider's contract with the Plan
    - The Plan's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution

Health Care Providers will be notified in writing of the determination of the Second Level Appeal Review within sixty (60) calendar days of the Plan's receipt of the Health Care Provider's request for a Second Level Appeal Review. The outcome of the Second Level Appeal Review is final.

In order to simplify resolution of Emergency Department payment level issues, which often arise because the claim was submitted without an Emergency Department summary and/or requires a review of medical records, participating hospital Providers are encouraged to address such payment issues through the Plan's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process.

Member Complaints, Grievances and Fair Hearings

The following are instructions that have been provided to the Member in their AmeriHealth Caritas Pennsylvania Member handbook on how they may file a Complaint, Grievance, request a Fair Hearing, or an External Grievance review, and how to continue to receive services during the process.

- **Note: The terms "you" or "your" in the following excerpt are referring to the Member.**

If a provider or **AmeriHealth Caritas Pennsylvania** does something that you are unhappy about or do not agree with, you can tell **AmeriHealth Caritas Pennsylvania** or the Department of Human Services what you are unhappy about or that you disagree with what the provider or **AmeriHealth Caritas Pennsylvania** has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell **AmeriHealth Caritas Pennsylvania** you are unhappy with **AmeriHealth Caritas Pennsylvania** or your provider or do not agree with a decision by **AmeriHealth Caritas Pennsylvania**.
Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that **AmeriHealth Caritas Pennsylvania** has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)** and tell **AmeriHealth Caritas Pennsylvania** your Complaint, or
- Write down your Complaint and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax, or
- If you received a notice from **AmeriHealth Caritas Pennsylvania** telling you **AmeriHealth Caritas Pennsylvania**'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax.

AmeriHealth Caritas Pennsylvania's address and fax number for Complaints:
Member Appeals Department
Attention: Member Advocate
AmeriHealth Caritas Pennsylvania
200 Stevens Drive
Philadelphia, PA 19113-1570
Fax number: 1-215-937-5367

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- **AmeriHealth Caritas Pennsylvania** has decided that you cannot get a service or item you want because it is not a covered service or item.
- **AmeriHealth Caritas Pennsylvania** will not pay a provider for a service or item you got.
- **AmeriHealth Caritas Pennsylvania** did not tell you its decision about a Complaint or Grievance you told **AmeriHealth Caritas** about within **30** days from when **AmeriHealth Caritas Pennsylvania** got your Complaint or Grievance.
- **AmeriHealth Caritas Pennsylvania** has denied your request to disagree with **AmeriHealth Caritas Pennsylvania**'s decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New Member appointment for your first examination…	**We will make an appointment for you…**
Members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a Member in **AmeriHealth Caritas Pennsylvania** unless you are already being treated by a PCP or specialist.
Members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a Member in **AmeriHealth Caritas Pennsylvania**, unless you are already being treated by a PCP or specialist.
Members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a Member in **AmeriHealth Caritas Pennsylvania,** unless you are already being treated by a PCP or specialist.
all other Members	with PCP no later than 3 weeks after you become a Member in **AmeriHealth Caritas Pennsylvania.**
Members who are pregnant:	**We will make an appointment for you . . .**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of **AmeriHealth Caritas Pennsylvania** learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of **AmeriHealth Caritas Pennsylvania** learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of **AmeriHealth Caritas Pennsylvania** learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of **AmeriHealth Caritas Pennsylvania** learning you are pregnant.
Appointment with…	**An appointment must be scheduled . . . . .**

PCP	
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.
routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	within 15 business days of referral
routine appointment with all other specialists	within 10 business days of referral

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from **AmeriHealth Caritas Pennsylvania** telling you that **AmeriHealth Caritas Pennsylvania** has received your Complaint, and about the First Level Complaint review process.

You may ask **AmeriHealth Caritas Pennsylvania** to see any information **AmeriHealth Caritas Pennsylvania** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **AmeriHealth Caritas Pennsylvania**.

You may attend the Complaint review if you want to attend it. **AmeriHealth Caritas Pennsylvania** will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more **AmeriHealth Caritas Pennsylvania** staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **AmeriHealth Caritas Pennsylvania** will mail you a notice within **30** days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see the Complaint process section.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint that is postmarked or received by AmeriHealth Caritas Pennsylvania within 15 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like AmeriHealth Caritas Pennsylvania's Decision?

You may ask for an external Complaint review, a Fair Hearing, or both, an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- **AmeriHealth Caritas Pennsylvania**'s decision that you cannot get a service or item you want because it is not a covered service or item.
- **AmeriHealth Caritas Pennsylvania**'s decision to not pay a provider not enrolled in the Medical Assistance Program for a service or item you got without authorization.
- **AmeriHealth Caritas Pennsylvania** decision to not pay a provider for a service or item you got, because the service or item is not a covered service for you.
- **AmeriHealth Caritas Pennsylvania**'s failure to decide a Complaint or Grievance you told **AmeriHealth Caritas Pennsylvania** about within **30** days from when **AmeriHealth Caritas Pennsylvania** got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it.
- **AmeriHealth Caritas Pennsylvania**'s decision to deny your request to disagree with AmeriHealth Caritas Pennsylvania's decision that you have to pay your provider.

You must ask for an external Complaint review by submitting your request in writing to the Pennsylvania Insurance Department's Bureau of Health Coverage Access within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**. To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department

Bureau of Consumer Services

Room 1209, Strawberry Square

Harrisburg, PA 17120

Fax: 1-717-787-8585

Or

Go to the "File a Complaint Page" at
https://www.insurance.pa.gov/Consumers/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at **1-877-881-6388**.

For information about Fair Hearings, see the Fair Hearings section.
For information about the external Complaint review, see the external Complaint review section.
If you need more information about help during the Complaint process, see the Complaint process section.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)** and tell **AmeriHealth Caritas Pennsylvania** your Second Level Complaint, or
- Write down your Second Level Complaint and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax.

AmeriHealth Caritas Pennsylvania's address and fax number for Second Level Complaints
Member Appeals Department

Attention: Member Advocate
AmeriHealth Caritas Pennsylvania
200 Stevens Drive
Philadelphia, PA 19113-1570
Fax number: 1-215-937-5367

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from **AmeriHealth Caritas Pennsylvania** telling you that **AmeriHealth Caritas Pennsylvania** has received your Complaint, and about the Second Level Complaint review process.

You may ask **AmeriHealth Caritas Pennsylvania** to see any information **AmeriHealth Caritas Pennsylvania** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **AmeriHealth Caritas Pennsylvania**.

You may attend the Complaint review if you want to attend it. **AmeriHealth Caritas Pennsylvania** will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for **AmeriHealth Caritas Pennsylvania**, will meet to decide your Second Level Complaint. The **AmeriHealth Caritas Pennsylvania** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee. **AmeriHealth Caritas Pennsylvania** will mail you a notice within **45** days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see the Complaint process section .

What if I Do Not Like AmeriHealth Caritas Pennsylvania's Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 1-717-787-8585
You can also go to the "File a Complaint Page" at:
https://www.insurance.pa.gov/Consumers/Pages/default.aspx . If you need help filing your request for external review, call the Bureau of Consumer Services at **1-877-881-6388.**

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Pennsylvania Insurance Department will get your file from **AmeriHealth Caritas Pennsylvania**. You may also send any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you AmeriHealth Caritas Pennsylvania's First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 15 days of the date on the notice telling you AmeriHealth Caritas Pennsylvania's First Level Complaint decision. If you wish to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

Grievances

What is a Grievance?

When **AmeriHealth Caritas Pennsylvania** denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you **AmeriHealth Caritas Pennsylvania**'s decision.

A Grievance is when you tell **AmeriHealth Caritas Pennsylvania** you disagree with **AmeriHealth Caritas Pennsylvania**'s decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)** and tell **AmeriHealth Caritas Pennsylvania** your Grievance, or
- Write down your Grievance and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from **AmeriHealth Caritas Pennsylvania** and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax.

AmeriHealth Caritas Pennsylvania's address and fax number for Grievances:
Member Appeals Department
Attention: Member Advocate
AmeriHealth Caritas Pennsylvania
200 Stevens Drive
Philadelphia, PA 19113-1570
Fax number: 1-215-937-5367

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from **AmeriHealth Caritas Pennsylvania** telling you that **AmeriHealth Caritas Pennsylvania** has received your Grievance, and about the Grievance review process.

You may ask **AmeriHealth Caritas Pennsylvania** to see any information that **AmeriHealth Caritas Pennsylvania** used to make the decision you filed your Grievance about at no cost to you.

You may also send information that you have about your Grievance to **AmeriHealth Caritas Pennsylvania.**

You may attend the Grievance review if you want to attend it. **AmeriHealth Caritas Pennsylvania** will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The **AmeriHealth Caritas Pennsylvania** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. **AmeriHealth Caritas Pennsylvania** will mail you a notice within 30 days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see the Grievance process section

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance that is postmarked or received by **AmeriHealth Caritas Pennsylvania** within 15 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made

What if I Do Not Like AmeriHealth Caritas Pennsylvania's Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for **AmeriHealth Caritas Pennsylvania.**

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see the Fair Hearings section.
For information about the external Grievance reviews, see below
If you need more information about help during the Grievance process, see the Grievance process section.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)** and tell **AmeriHealth Caritas Pennsylvania** your Grievance, or
- Write down your Grievance and send it to **AmeriHealth Caritas Pennsylvania** by mail to:

  Member Appeals Department
  Attention: Member Advocate
  AmeriHealth Caritas Pennsylvania
  200 Stevens Drive
  Philadelphia, PA 19113-1570
  Fax number: 1-215-937-5367

AmeriHealth Caritas Pennsylvania will send your request for external Grievance review to the Pennsylvania Insurance Department.

What Happens After I Ask for an External Grievance Review?

AmeriHealth Caritas Pennsylvania will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

AmeriHealth Caritas Pennsylvania will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 20 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a written request that is postmarked or received by the Pennsylvania Insurance Department within 20 days of the date on the notice telling you **AmeriHealth Caritas Pennsylvania**'s Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 15 days of the date on the notice telling you **AmeriHealth Caritas Pennsylvania**'s Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, Services will not continue

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30** days to get a decision about your First Level Complaint or Grievance, or **45** days to get a decision about your Second Level Complaint, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask **AmeriHealth Caritas Pennsylvania** for an early decision by calling **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)**, faxing a letter or the Complaint/Grievance Request Form to **1-215-937-5367,** or sending an email to **PAmemberappeals@amerihealthcaritas.com**.

- Your doctor or dentist should fax a signed letter to **1-215-937-5367** within 72 hours of your request for an early decision that explains why **AmeriHealth Caritas Pennsylvania** taking **30** days to get a decision about your First Level Complaint or Grievance, or **45** days to get a decision about your Second Level Complaint, could harm your health.

If **AmeriHealth Caritas Pennsylvania** does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, **AmeriHealth Caritas Pennsylvania** will decide your Complaint or Grievance in the usual time frame of **30** days from when **AmeriHealth Caritas Pennsylvania** first got your First Level Complaint or Grievance, or **45** days from when **AmeriHealth Caritas Pennsylvania** got your Second Level Complaint.

Expedited Complaint and Expedited External Complaint

A committee of 1 or more people, including a licensed doctor or licensed dentist will review your expedited Complaint. Other providers may participate in the review but, the licensed doctor or licensed dentist will decide your Complaint.. The **AmeriHealth Caritas Pennsylvania** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue
you filed your Complaint about.
You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because **AmeriHealth Caritas Pennsylvania** has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

AmeriHealth Caritas Pennsylvania will tell you the decision about your Complaint within 48 hours of when **AmeriHealth Caritas Pennsylvania** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when **AmeriHealth Caritas Pennsylvania** gets your request for an early decision, whichever is sooner, unless you ask **AmeriHealth Caritas Pennsylvania** to take more time to decide your Complaint. You can ask **AmeriHealth Caritas Pennsylvania** to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Pennsylvania Insurance Department within **2 business days from the date you get the expedited Complaint decision notice**. To ask for an expedited external review of a Complaint, send your request to the following:

Pennsylvania Insurance Department

Bureau of Consumer Services

Room 1209, Strawberry Square

Harrisburg, PA 17120

Fax: 1-717-787-8585

or

Go to the "File a Complaint Page" at
https://www.insurance.pa.gov/Consumers/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at **1-877-881-6388**.

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the expedited Grievance review committee will include a dentist. The **AmeriHealth Caritas Pennsylvania** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because **AmeriHealth Caritas Pennsylvania** has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

AmeriHealth Caritas Pennsylvania will tell you the decision about your Grievance within 48 hours of when **AmeriHealth Caritas Pennsylvania** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when **AmeriHealth Caritas Pennsylvania** gets your request for an early decision, whichever is sooner, unless you ask **AmeriHealth Caritas Pennsylvania** to take more time to decide your Grievance. You can ask **AmeriHealth Caritas Pennsylvania** to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call **AmeriHealth Caritas Pennsylvania** at **1-888-991-7200 (TTY 1-888-987-5704)** and tell **AmeriHealth Caritas Pennsylvania** your Grievance, or
- Send an email to **AmeriHealth Caritas Pennsylvania** at **PAmemberappeals@amerihealthcaritas.com** or
- Write down your Grievance and send it to **AmeriHealth Caritas Pennsylvania** by mail or fax:
  Member Appeals Department
  Attention: Member Advocate
  AmeriHealth Caritas Pennsylvania
  200 Stevens Drive
  Philadelphia, PA 19113-1570
  Fax number: 1-215-937-5367

AmeriHealth Caritas Pennsylvania will send your request to the Pennsylvania Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Process?

If you need help filing your Complaint or Grievance, a staff member of **AmeriHealth Caritas Pennsylvania** will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell **AmeriHealth Caritas Pennsylvania**, in writing, the name of that person and how **AmeriHealth Caritas Pennsylvania** can reach him or her.

You or the person you choose to represent you may ask **AmeriHealth Caritas Pennsylvania** to see any information **AmeriHealth Caritas Pennsylvania** has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call **AmeriHealth Caritas Pennsylvania**'s toll-free telephone number at **1-888-991-7200 (TTY 1-888-987-5704)** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **1-800-322-7572** or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Persons Whose Primary Language Is Not English

If you ask for language services, **AmeriHealth Caritas Pennsylvania** will provide the services at no cost to you.

Persons with Disabilities

AmeriHealth Caritas Pennsylvania will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by **AmeriHealth Caritas Pennsylvania** at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

Department of Human Services Fair Hearings

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something **AmeriHealth Caritas Pennsylvania** did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after **AmeriHealth Caritas Pennsylvania** decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked, faxed, or submitted via email* within **120 days from the date on the notice** telling you **AmeriHealth Caritas Pennsylvania**'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- **AmeriHealth Caritas Pennsylvania**'s failure to decide a First Level Complaint or Grievance you told **AmeriHealth Caritas Pennsylvania** about within **30** days from when **AmeriHealth Caritas Pennsylvania** got your Complaint or Grievance.
- The denial of your request to disagree with **AmeriHealth Caritas Pennsylvania**'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that **AmeriHealth Caritas Pennsylvania** failed to decide a First Level Complaint or Grievance you told **AmeriHealth Caritas Pennsylvania** about within **30** days from when **AmeriHealth Caritas Pennsylvania** got your Complaint or Grievance.

*** Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.**

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter or email* it needs to include the following information:

- Your (the Member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

*Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

You must send your request for a Fair Hearing to the following address

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

Fax: 1-717-772-6328
Email: RA-PWCGFHteam@pa.gov

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

AmeriHealth Caritas Pennsylvania will also go to your Fair Hearing to explain why **AmeriHealth Caritas Pennsylvania** made the decision or explain what happened.

You may ask **AmeriHealth Caritas Pennsylvania** to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **AmeriHealth Caritas Pennsylvania**, not including the number of days between the date on the written notice of the **AmeriHealth Caritas Pennsylvania**'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because **AmeriHealth Caritas Pennsylvania** did not tell you its decision about a Complaint or Grievance you told **AmeriHealth Caritas Pennsylvania** about within **30** days from when **AmeriHealth Caritas Pennsylvania** got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **AmeriHealth Caritas Pennsylvania**, not including the number of days between the date on the notice telling you that **AmeriHealth Caritas Pennsylvania** failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at **1-800-798-2339** to ask for your services.

What to do to continue getting services:
If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or received by the Department of Human Services within 15 days of the date on the notice telling you AmeriHealth Caritas Pennsylvania's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at **1-800-798-2339**, by faxing a letter or the Fair Hearing Request Form to **1-717-772-6328**, or submitting a written request electronically via email* to **RA-PWCGFHteam@pa.gov**. Your doctor or dentist must fax a signed letter to **1-717-772-6328** explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter,

your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email

You may call **AmeriHealth Caritas Pennsylvania**'s toll-free telephone number at **1-888-991-7200 (TTY 1-888-987-5704)** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **1-800-322-7572** or call the Pennsylvania Health Law Project at **1-800-274-3258**.

Provider Information:

General Procedures for Complaints and Grievances

The following procedures apply to all levels of Complaints and Grievances for Members:

1. The Plan does not charge Members a fee for filing a Complaint or Grievance at any level.
2. The Plan designates and trains sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with applicable requirements and using letter templates supplied by DHS.
3. The Plan staff performing Complaint and Grievance reviews has the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.
4. The Plan does not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Member from receiving Medically Necessary care in a timely manner.
5. The Plan accepts Complaints and Grievances from individuals with disabilities in alternative formats, including: TTY/TDD (for telephone inquiries and Complaints and Grievances from Members who are hearing impaired), Braille, audio tape, computer disk and other commonly accepted alternative forms of communication. The Plan informs employees who receive telephone Complaints and Grievances of the speech limitation of some Members with disabilities so they can treat these individuals with patience, understanding, and respect.
6. The Plan offers Members the assistance of the Plan staff throughout the Complaint and Grievance process at no cost to the Member. The Plan also offers Members the opportunity to be represented by a Plan staff member at no cost to the Member.

7. The Plan ensures that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not the subordinate of anyone who was involved in any previous level of review or decision-making in the case at issue.
8. The Plan permits the Member or Member representative (which includes the Member's Health Care Provider), with proof of the Member's written authorization or consent for the representative to be involved and/or act on the Member's behalf, to file a Complaint or Grievance either verbally or in writing. The written authorization or consent must comply with applicable laws, contract requirements and the Plan procedures. Health Care Providers wishing to file a Complaint on behalf of a Member must have the Member's written consent. There are separate consent requirements for Grievances under Act 68 which are not applicable to Complaints. For more information on the specific consent requirements for Grievances, please see the section titled "Requirements for Grievances filed by Providers on Behalf of Members" found in this Section of the Manual.
9. At any time during the Complaint and Grievance process, the Member or their representative may request access to documents, copies of documents, records, and other information relevant to the subject of the Complaint or Grievance. This information is provided at no charge.
10. If The Plan does not decide a First Level Complaint or Grievance within the timeframes specified within the Policy, the Plan notifies the Member and other appropriate parties using a DHS approved letter template. The letter is mailed by The Plan one day following the date the decision on the First Level Complaint or Grievance was to be made.
11. Oral requests for Complaints and Grievances are committed to writing by the Plan and provided to the Member and Member representative for signature through a DHS approved acknowledgement letter. The signature may be obtained at any point in time in the Complaint and Grievance process. If the Member or Member representative's signature is not received, the Complaint or Grievance is not delayed.
12. The Plan provides Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes: providing qualified sign language interpreters for Members who are severely hearing impaired, providing personal assistance to Members with other physical limitations in copying and presenting documents and other evidence, and providing information submitted on behalf of the Plan at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version will be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review.
13. The Plan provides language interpretation services in the Member's preferred language when requested by a Member, at no cost to the Member.
14. A Member who consents to the filing of a Complaint or Grievance by a Health Care Provider may not file a separate Complaint or Grievance. The Plan will ensure that punitive action is not taken against a Health Care Provider who either requests an Expedited Resolution of a Complaint or Grievance or supports a Member's request for an Expedited Review of a Complaint or Grievance. The Member retains the right to rescind consent throughout the

Complaint and Grievance process upon written notice to the Plan and the Health Care Provider.

15. The Member or Member representative has the opportunity to submit written documents, comments or other information relating to the Complaint or Grievance, and to present evidence and testimony and make legal and factual arguments in person, as well as in writing, at both levels of the internal Complaint and Grievance process.
16. The Plan takes into account all information submitted by the Member or Member representative regardless of whether such information was submitted or considered during the initial or prior level of review.
17. The Plan is flexible when scheduling the review to facilitate the Member's attendance. The Member is given at least ten (10) days advance written notice of the review date for First Level Reviews. The Member is given at least fifteen (15) days advance written notice of the review date for Second Level Reviews.
18. If the Member cannot appear in person at the review, the Plan provides the Member with an opportunity to communicate with the committee by telephone. The Member may elect not to attend the review meeting, but the meeting is conducted with the same protocols as if the Member were present.
19. Committee proceedings are informal and impartial to avoid intimidating the Member or Member representative. Persons attending the committee meeting and their respective roles at the review will be identified for the Member and Member representative in attendance.
20. The committee may question the Member and the Member representative, the Health Care Provider and the Plan staff representing the Plan's position.
21. A committee Member who does not personally attend the review may not be part of the decision-making process unless that committee Member actively participates in the review by telephone and has the opportunity to review all information introduced during the review.
22. Members and their representatives may also pursue issues through the separate and distinct DHS Fair Hearing process. Members or their representatives may file a request for a DHS Fair Hearing or an expedited DHS Fair Hearing after the Complaint and Grievance process has been exhausted.

Relationship of Provider Formal Appeals Process to Provider Initiated Member Grievances

If a Health Care Provider submits a request for an appeal through the Plan's Grievance Appeals Process and a Member consent has been provided that conforms with applicable law for Act 68 Member Appeals filed by a Health Care Provider on behalf of a Member (specific requirements for Health Care Providers related to Grievances filed by Providers on Behalf of Members are set forth below), the appeal will be processed through the Plan's Act 68 Member Grievance Process.

If the appeal is processed through the Act 68 Member Grievance Process, the Health Care Provider waives his/her right to file an appeal through The Plan's Formal Provider Appeals Process, unless otherwise specified in the Health Care Provider's contract with the Plan.

If a Health Care Provider, with written consent of the Member, appeals a denial through the Act 68 Member Grievance Process at any time prior to or while the Formal Provider Appeal is pending, the Formal Provider Appeal will be terminated and the Formal Provider Appeal closed. The Plan will notify the Health Care Provider in writing if a Formal Provider Appeal has been closed for this reason.

Requirements for Grievances filed by Providers on Behalf of Members

Member Consent Requirements for Grievances

Pennsylvania Act 68 gives Health Care Providers the right, with the written permission of the Member, to pursue a Grievance on behalf of a Member. A Health Care Provider may ask for a Member's written consent in advance of treatment but may not require a Member to sign a document allowing the filing of a Grievance by the Health Care Provider as a condition of treatment. There are regulatory requirements for Health Care Providers that specify items that must be in the document giving the Health Care Provider permission to pursue a Grievance on behalf of a Member, and the time frames to notify Members of the Health Care Provider's intent to pursue or not pursue a Grievance on behalf of a Member. These requirements are important because the Health Care Provider assumes the Grievance rights of the Member.

The Member may rescind the consent at any time during the Grievance process. If the Member rescinds consent, the Member may continue with the Grievance at the point at which consent was rescinded. The Member may not file a separate Grievance for the same issue listed in the consent form signed by the Member which the Health Care Provider is pursuing. A Member who has filed a Grievance may, at any time during the Grievance process, choose to provide consent to a Health Care Provider to continue with the Grievance instead of the Member. The Member's consent is automatically rescinded upon the failure of the Health Care Provider to file or pursue a Grievance on behalf of the Member. The Health Care Provider, having obtained consent from the Member or the Member's legal representative to file a Grievance, has 10 days from receipt of the Medical Necessity denial and any decision letter from a First, Second or External Review upholding The Plan's decision to notify the Member or the Member's legal representative of his or her intention not to pursue a Grievance.

It is important for Health Care Providers to remember they may not bill The Plan Members for covered services. If a Health Care Provider assumes responsibility for filing a Grievance and the subject of the Grievance is for non-covered services provided, then the Health Care Provider may not bill the Member until the External Grievance Review is completed or the Member rescinds consent for the Health Care Provider to pursue the Grievance. If the Health Care Provider chooses to never bill the Member for non-covered services that are the subject of the Grievance, the Health Care Provider may drop the Grievance with notice to the Member.

The consent document giving the Health Care Provider authority to pursue a Grievance on behalf of a Member shall be in writing and must include each of the following elements:

- The name and address of the Member, the Member's date of birth, and the Member's identification number.
- If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signs the consent for the Member.
- The name, address and identification number of the Health Care Provider to whom the Member is providing the consent.
- The name and address of the plan to which the Grievance will be submitted.
- An explanation of the specific service for which coverage was provided or denied to the Member to which the consent will apply.
- The following statements:
    - The Member or the Member's representative may not submit a Grievance concerning the services listed in this consent form unless the Member or the Member's legal representative rescinds consent in writing. The Member or the Member's legal representative has the right to rescind consent at any time during the Grievance process.
    - The consent of the Member or the Member's legal representative is automatically rescinded if the Health Care Provider fails to file a Grievance, or fails to continue to prosecute the Grievance through the Review Process.
    - The Member or the Member's legal representative, if the Member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member or the Member's legal representative understands the information in the Member's consent form.
- The consent document must also have the dated signature of the Member, or the Member's legal representative if the Member is a minor or is legally incompetent, and the dated signature of a witness.

Note: The Pennsylvania Department of Health has developed a standard Enrollee (Member) consent form that complies with the provisions of Act 68. The form can be found at under "Provider Initiated Grievance and Enrollee Consent Form" on the Pennsylvania Department of Health website.

Escrow Requirements for External Grievances (Including Expedited External Grievances)

If a Health Care Provider requests an External Grievance Review, the Health Care Provider and the Plan must each establish escrow accounts in the amount of half the anticipated cost of the review. The Health Care Provider will be given more specific information about the escrow requirement at the time of the filing of the External Grievance. If the External Grievance Decision is against the Plan, in part or in full, the Plan pays the cost. If the decision is against the Member, in part or in full,

the Plan pays the cost. If the decision is against the Health Care Provider in full, the Health Care Provider pays the cost.

Section 8: Quality Assessment Performance Improvement, Credentialing, and Utilization Management

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPI) is an integrative process that links together the knowledge, structure and processes throughout a Managed Care Organization to assess and improve quality. This process also assesses and improves the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care and services are provided.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure for the continuous monitoring, evaluation, and improvement in care and service. The QAPI Program is broad in scope and encompasses the range of clinical and service issues relevant to Members. The scope includes quality of clinical care, quality of service, and preventive health services. The QAPI Program continually monitors and reports analysis of aggregate data, intervention studies and measurement activities, programs for populations with Special Healthcare Needs and surveys to fulfill the activities under its scope. The QAPI Program centralizes and uses performance monitoring information from all areas of the organization and coordinates quality improvement activities with other departments.

Objectives

The objectives of the QAPI Program are to systematically develop, monitor and assess the following activities:

- Maximize utilization of collected information about the quality of clinical care and service and to identify clinical and service improvement initiatives for targeted interventions.
- Ensure adequate practitioner and Provider availability and accessibility to effectively serve the membership.
- Maintain credentialing/recredentialing processes to assure that the Managed Care Organization's network is comprised only of qualified practitioners/Providers.
- Oversee the functions of delegated activities.
- Continue to enhance physician profiling process and optimize enhanced systems to communicate performance to participating practitioners.
- Coordinate services between various levels of care, Network Providers, and community resources to assure continuity of care.
- Optimize Utilization Management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards.
- To ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization.
- Utilize Member and Network Provider satisfaction study results when implementing quality activities.

- Implement and evaluate Disease Management programs to effectively address chronic illnesses affecting the membership.
- Maintain compliance with evolving National Committee for Quality Assessment (NCQA) accreditation standards.
- Communicate results of our clinical and service measures to Network Providers, and Members.
- Identify, enhance and develop activities that promote Member safety.
- Document and report all monitoring activities to appropriate committees.

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the QM Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives.

QAPI Program effectiveness is evaluated on an annual basis. This assessment allows the Plan to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to Plan membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QI work plan. Feedback and recommendations from various committees are incorporated into the evaluation.

Quality Assessment and Performance Improvement Program Authority and Structure

The Plan's Quality Assessment and Performance Improvement Committee (QAPIC) provides leadership in the Plan's efforts to measure, manage and improve quality of care and services delivered to Members and to evaluate the effectiveness of the Plan's QAPI Program through measurable indicators. All other quality-related committees report to the QAPIC.

Other quality-related committees include the following:

Credentialing Committee

The Credentialing Committee is a peer review committee whose purpose is to review Providers' credentialing/recredentialing application information in order to render a decision regarding qualification for membership to the Plan's Network.

Health Education Advisory Committee

The Health Education Advisory Committee is responsible for advising on the health education needs of the Plan, specifically as they relate to public health priorities and population-based initiatives. The Health Education Advisory Subcommittee is also responsible for ensuring

coordination of health education activities with DHS for the benefit of the entire HealthChoices population or populations with Special Healthcare Needs.

Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee is responsible for evaluating the clinical efficacy, safety, and cost-effectiveness of medications in the treatment of disease states through product evaluation and drug Formulary recommendations. The Subcommittee also uses drug prescription patterns to develop Network Provider educational programs.

Quality Assessment and Performance Improvement Committee (QAPIC)

The Quality Assessment and Performance Improvement Committee (QAPIC) coordinates the Plan's efforts to measure manage and improve quality of care and services delivered to the Plan Members and evaluate the effectiveness of the QAPI Program. It is responsible for directing the activities of all clinical care delivered to Members.

Quality of Service Committee (QSC)

The QSC is responsible for measuring and improving services rendered to Members and Providers in the Member Services, Claims, Provider Services, and Provider Network Management Departments.

Operational Compliance Committee

The purpose of the Operational Compliance Committee (OCC) is to assist the Chief Compliance Officer and the Privacy Officer with the implementation and maintenance of the Corporate Compliance and Privacy Programs.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, Members' and Health Care Providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Credentialing/Recredentialing Requirements

Provider Requirements

The Plan maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and NCQA accreditation standards governing credentialing and recredentialing functions.

The following types of practitioners require initial credentialing and recredentialing (every 36 months):

- Audiologist (AUD)
- Chiropractor (DC)
- Certified Nurse Midwife (CNM)
- Certified Nurse Practitioner (CRNP/APN)
- Dentist (DDS and DMD) (including General Dentists and Pediatric Dentists)
- Medical Doctor (MD and DO)
- Occupational Therapist (OT)*
- Oral Surgeon (DDS)
- Physical Therapist (PT)
- Podiatrist (DPM)
- Speech and Language Therapist (SLP)*
- Therapeutic Optometrist (OD)
- Registered Dietician (RD)

*Only private practices (practitioners who have an independent relationship with the Plan) require credentialing.

Hospital based practitioners practicing exclusively in the inpatient setting are not credentialed or recredentialed by the Health Plan. Hospital based practitioners are defined as, but not limited to Pathologists, Anesthesiologists, Radiologists, Emergency Medicine, Neonatologists, and Hospitalists.

Locum tenens employed by a healthcare system or a hospital would be required to be credentialed by that organization or for that organization by another credible body. If the provider will be serving for a longer term, greater than 60 days, and credentialing is not delegated to the organization, or its surrogate, the Plan will credential those locum tenens identified by the organization.

The following criteria must be met as applicable, in order to evaluate a qualified Health Care Provider:

- A current, active and unrestricted Individual Medicaid number along with service location numbers for each address contracted with The Plan (applications submitted without an active Medicaid or PPID number must be accompanied by a copy of the enrollment application; individual and/or service location applications).
- An individual NPI and group number.
- A current unrestricted state license, not subject to probation, proctoring requirements or disciplinary action. A copy of the license must be submitted along with the application.
- A valid DEA or CDS certificate, if applicable. The DEA certificate must list the State on the address where the practitioner is treating Members. The DEA certificate is non-

transferrable by location. If the practitioner has chosen not to prescribe, they must submit a letter notifying us that they will not be prescribing and have not obtained a DEA license.

- Education and training that supports the requested specialty or service, as well as the degree credential of the Health Care Provider.
- Foreign trained Health Care practitioners must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number with the application.
- Board Certification Certificate, if applicable or National Certification Certificate for CRNP's/PA's, if applicable.
- The following board organizations are recognized by the Plan for purposes of verifying specialty board certification:
    - American Board of Medical Specialties – ABMS
    - American Medical Association - AMA
    - American Osteopathic Association - AOA
    - American Board of Podiatric Surgeons - ABPS
    - American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
    - American Board of Foot and Ankle Surgery
    - Royal College of Physicians and Surgeons
- Work history containing current employment, as well as explanation of any gaps within the last (5) years.
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Health Care practitioner in the past 5 years.
- A current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of $500,000/$1.5million with excess coverage of $500,000/$1.5 million) – total coverage should equal $1million/$3 million. Malpractice insurance may also be listed on the application in lieu of a face sheet as long as the effective date, expiration date, policy number, and limits of liability are included on the application. A Federal Tort Letter is also acceptable insurance.
- Hospital admitting arrangements (for Primary Care Providers (PCPs) with an institution participating with the Plan or, as an alternative, those Health Care Providers who do not have admitting hospital privileges, may enter into an admitting arrangement with a participating Health Care practitioners who has admitting privileges at a participating hospital. Those practitioners who do not have admitting privileges may also utilize a hospitalist service at a Plan participating hospital.
- Collaborative Agreement for CRNP's and CNM's with a Supervising physician who is a Plan participating physician.
- Explanation to any affirmative answers on the "General Questions" section of the application.
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable. CLIA certificate is required for all addresses where the practitioner has laboratory services in the office Plan Members are being treated.
- Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization.

Practitioner Application

The Plan offers practitioners the Universal Provider Data source through an agreement with The Council for Affordable Quality Healthcare (CAQH) that simplifies and streamlines the data collection process for credentialing and recredentialing.

Through CAQH, credentialing information is provided to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to practitioners to participate in CAQH or to submit applications. The Plan encourages all practitioners to utilize this service.

Submit your application to participate with the plan via CAQH (**www.caqh.org**):

- Register for CAQH
- Grant authorization for the Plan to view your information in the CAQH database
- Send your CAQH ID number to the Plan at **provider.credentialinghbg@amerihealthcaritaspa.com**

Paper Application Process

- Complete a PA Standard application and attestation that includes the practitioner's signature and current date.
- Sign and date a release of information form that grants permission to contact outside agencies to verify or supply information submitted on the applications.
- Submit all License, DEA, Board Certification, Education and Training, Hospital Affiliation and other required information with the application, which will be verified directly through the primary sources prior to the credentialing/recredentialing decision.
- Submit a PROMISe™/Medicaid number issued by DHS along with the PPID/Service Location number for all addresses where the practitioner will be rendering services to the Plan's Members. If the Medicaid PPID number has not yet been received, a copy of the PPID enrollment application must be submitted along with the credentialing/recredentialing application.

As part of the application process, the Plan will:

- Request information on Health Care practitioner sanctions prior to making a credentialing or recredentialing decision. Information from the National Practitioner Data Bank (NPDB), Medicheck (Medicaid exclusions), HHS Office of Inspector General (Medicaid/Medicare exclusions) through Provider Trust, System for Awards Management (SAM) through Provider Trust, Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS), Social Security Death Master File (SSDMF) through Provider Trust and Pennsylvania State Disciplinary Action report will be reviewed as applicable.

- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assessment (NCQA), State and Federal regulations.
- Performance review of complaints, quality of care issues and utilization quality concerns will be reviewed on a quarterly basis by the Quality Management Department. A summary of their review will be presented at the QAPI. A Quality Recredentialing Profile will also be completed for all practitioners and providers due for recredentialing and will be presented to the Credentialing Committee as necessary.
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing.
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

Presentation to the Medical Director or Credentialing Committee

Once all information is received and primary source verifications are completed the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director.
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

After the submission of the application, Health Care Practitioners:

- Have the right to review the credentialing/recredentialing information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by the Plan.
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the practitioner provided, the Credentialing Department will notify the Health Care practitioner to correct the discrepancy. The Provider will have 10 business days from the date of the notification to correct the erroneous information. The practitioner can submit the correction either by email, fax, or phone to the Credentialing department. Receipt of corrected information will be documented in the practitioner's credentialing file.
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application. The Credentialing department will share all information with the practitioner exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the practitioner.

- Have the right to be notified within 60 calendar days of the Credentialing Committee decision.
- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the Provider should contact the Plan's Credentialing Department at the following address:

AmeriHealth Caritas Pennsylvania
ATTN: Credentialing Department
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-800-642-3510
Fax: 1-215-863-6369

Facility Requirements

Facility Providers must meet the following criteria:

- The Plan will confirm that the facility is in good standing with all state and regulatory bodies, and has been reviewed by an accredited body as applicable. If there are no accreditation status results, a current CMS State Survey will be accepted. If the Facility is not accredited and does not have A CMS State Survey, the Plan will schedule a site visit of the facility. Recertification of facilities must occur at least every 36 months
- The following types of facilities are credentialed and re-credentialed
    - Hospitals (acute care and acute rehabilitation)
    - Skilled Nursing Facilities (SNF)
    - Skilled Nursing Facilities providing sub-acute services
    - Nursing Homes
    - Sub-Acute Facilities
    - Home Health Agencies
    - Hospice
    - Ambulatory Surgical Center (ASC)
    - Durable Medical Equipment
    - Dialysis Centers
    - Free Standing Sleep Centers/Sleep Labs
    - Free Standing Radiology Centers
    - Diabetic Education Programs
    - Portable X-ray Suppliers/Imaging Centers

The following information must be submitted with the credentialing application:

- A current copy of the facility's unrestricted license not subject to probation, suspension, or other disciplinary action limits;

- A current copy of the facilities malpractice coverage and history of liability
- A current copy of the accreditation certificate or letter or current CMS State Survey, if applicable(if the facility is not accredited and has not had a CMS State Survey, or letter from CMS, or if the most recent survey is older than 3 years old at the time of verification, the Plan will schedule a site visit of the facility);
- The facility must submit a PROMISe™/Medicaid number issued by DHS under which service will be rendered. If the facility is not yet enrolled, a copy of the enrollment application to DHS must be submitted with the application;
- The facility must submit an active Medicare number, if applicable;
- The facility must submit a Group NPI number;
- Ownership disclosure form

Facility Application

Facilities must:

- Complete the facility application with signature and current date from the appropriate facility officer. A facility application must be completed for each location where the provider renders services to Plan Members. Supporting documents noted above must be provided for each location.
    - Note: A parent facility with branch locations is required to submit one application listing all addresses. A copy of one license, accreditation or CMS State Survey, and malpractice insurance is also required. Proof that additional locations are branch locations must also be provided (this is usually documented on the Accreditation Certificate or CMS State Survey).
- Attest to the accuracy and completeness of the information submitted to the Plan.
- Submit documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance.

The Plan will:

- Verify the facility's status with state regulatory agencies through the State Department of Health
- Request information on facility sanctions prior to rendering a credentialing or recredentialing decision, by obtaining information from the National Practitioners Data Band (NPDB), Medicheck (Medicaid exclusions) ,HHS Office of Inspector General (Medicaid/Medicare exclusions) through Provider Trust, and System for Award Management (SAM) through Provider Trust
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing.
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

After the submission of the application, Facilities:

- Have the right to review the information submitted to support their credentialing/recertification application, with the exception of recommendations, and peer protected information obtained by the Plan*;
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy. The provider will have 10 business days to correct the erroneous information;
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application.* The Credentialing department will share all information with the provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the provider.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision; and,
- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the provider should contact the Plan's Credentialing Department at the following address:

AmeriHealth Caritas Pennsylvania
ATTN: Provider Contracting
8040 Carlson Road, Suite 500
Harrisburg, PA 17112
Phone: 1-800-642-3510
Fax: 1-717-651-1673

Presentation to the Medical Director or Credentialing Committee:

Once all information is received and primary source verifications are completed the facility file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination.

All practitioners and facilities are required to be re-credentialed or recertified at a minimum of every 36 months. All items noted in the Credentialing section are required at the time of re-credentialing or recertification, with the exception of work history and education for practitioners. All primary source verifications noted above are conducted at the time of re-credentialing and recertification. Presentation to the Medical Director or Credentialing Committee occurs for recredentialing files as noted above.

Member Access to Physician Information

Members can call Member Services to request information about Network Providers, such as where they went to medical school, where they performed their residency, and if the Network Provider is board-certified.

Provider Sanctioning Policy

It is the goal of the Plan to assure Members receive quality health care services. In the event that health care services rendered to a Member by a Network Provider represent a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community, the Network Provider may be subject to the Plan's formal sanctioning process.

Prohibition on Payment to Excluded/Sanctioned Persons

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, the Plan may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletin (MAB) 99-11-05 requires all providers who participate in Medicare, Medicaid or any other federal health care program to screen their employees and contractors, both individuals and entities, before employing or contacting with them and to rescreen all employees on an on-going monthly basis, to determine if they have been excluded from participation in any of the aforementioned programs. Examples of individuals (as outlined in MAB 99-11-05) that should be screened include, but are not limited to the following:

- An individual or entity who provides a service for which a claim is submitted to Medicaid;
- An individual or entity who causes a claim to be generated to Medicaid;
- An individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as providers who send a Medicaid recipient to another provider for additional services or second opinion related to a medical condition.

All federal health care programs, including The Plan are prohibited from paying for any items or services furnished, ordered, directed or prescribed by excluded individuals or entities.

For complete details, MAB 99-11-05 is posted on the Provider Center at **www.amerihealthcaritaspa.com → Providers → Communications → DHS/Medical Assistance Bulletins**.

Resources:

Pennsylvania Medicheck List is a data base maintained by DHS that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program: **https://www.pa.gov/agencies/dhs/report-fraud/medicheck-list.html** **List of Excluded Individuals/Entities (LEIE)** is a data base maintained by HHS- OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although DHS makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program: **https://oig.hhs.gov/exclusions/index.asp**

The System for Award Management (SAM) is an official website of the U.S. government to search for entity registration and exclusion records: **https://sam.gov/**

Upon request of the Plan, a Provider will be required to furnish a written certification to the Plan that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to immediately notify the Plan upon knowledge that any of its contractors, employees, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that a Provider cannot provide reasonably satisfactory assurance to the Plan that a Sanctioned Person will not receive payment from the Plan under the Provider Agreement, the Plan may immediately terminate the Provider Agreement. The Plan reserves the right to recover all amounts paid by the Plan for items or services furnished by a Sanctioned Person.

All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When the Plan's Quality Department identifies a potential quality concern regarding care and/or services being delivered by a Network Provider, the clinical information is presented to The Plan's Medical Director. The Medical Director may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

- The Quality Management Department sends a letter of notification to the Network Provider. The letter will describe the quality concerns and outlines what actions are recommended for correction of the concern. The Network Provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the Network Provider must correct the concern.
    - **The letter is to be clearly marked:**
      Confidential: Product of Peer Review
- The Network Provider is required to respond to the request within the timeframe indicated in the notification.
- Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, the Plan's quality standards, and/or recognized treatment patterns of the organized medical community, the Plan's Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The Network Provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the Network Provider of his/her right to a hearing before a hearing panel.
- The Network Provider's current Member panel (if applicable) and referrals and/or admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The Network Provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action
- That the Network Provider has the right to request a hearing on the proposed action
- That the Network Provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The Network Provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The Network Provider may waive his/her right to a hearing

Notice of Hearing

If the Network Provider requests a hearing in a timely manner, the Network Provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice.
- That the Network Provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of the Plan and/or upon the advice of the Plan's Legal Department.
- A list of witnesses (if any) expected to testify at the hearing on behalf of the Plan.

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by the Plan.
- Individuals on the panel will not be in direct economic competition with the Network Provider involved, nor will they have participated in the initial decision to propose Sanctions.
- The panel will be composed of physician members of the Plan's Quality Committee structure, the CMO of the Plan, and other physicians and administrative persons affiliated with the Plan as deemed appropriate by the CMO of the Plan. The Plan CMO or his/her designee serves as the hearing officer.
- The right to the hearing will be forfeited if the Network Provider fails, without good cause, to appear.

Provider's Rights at the Hearing

The Network Provider has the right:

- To representation by an attorney or other person of the Network Provider's choice;
- To have a record made of the proceedings (copies of which may be obtained by the Network Provider upon payment of reasonable charges);
- To call, examine, and cross-examine witnesses;
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law;
- To submit a written statement at the close of the hearing;
- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s);
- To receive the Plan's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation.

Appeal of the Decision of the Plan Peer Review Committee

The Network Provider may request an appeal after the final decision of the Panel

- The Plan Quality Improvement Committee must receive the appeal by certified mail within 30 days of the Network Provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited.
- Written appeal will be reviewed and a decision rendered by the Plan Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal.

Summary Actions Permitted

The CEO, President of PA Managed Care, the Executive Vice President and Chief Operating Officer, and/or the CMO, can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action.
- Immediate revocation, in whole or in part, of panel membership or Network Provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action.

External Reporting

The CMO will direct the Credentialing Department to prepare an adverse action report for submission to the National Practitioner Data Bank (NPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a Network Provider will materially affect the Plan's ability to make available all capitated services in a timely manner, the Plan will notify DHS of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement the Plan's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with DHS requirements, the National Committee for Quality Assessment (NCQA), Pennsylvania's Act 68 and accompanying Regulations, and other applicable State and federal laws and regulations. Where standards conflict, the Plan adopts the most rigorous of the standards.

Annual Review

Annually, the Plan reviews and updates it's UM and policies and procedures as applicable. These modifications, which are approved by the Plan Medical Management Committee, are based on, among other things, changes in laws, regulations, DHS requirements, accreditation requirements, industry standards and feedback from Health Care Providers, Members and others.

Mission and Values

The Plan UM Program provides an interactive process for Members that generally assesses whether the physical health care services they receive are Medically Necessary and delivered in a quality manner. Behavioral health services are provided through a separate arrangement between DHS and Behavioral Health Managed Care Organizations. The Plan UM Program promotes the continuing education of, and understanding amongst, Members, participating physicians and other healthcare professionals.

UM Program techniques that are used to evaluate medical necessity, access, appropriateness and efficiency of services include, but are not limited to, the following programmatic components: intake, Prior Authorization, concurrent review, discharge planning and alternate service review, DME review. The UM Program also generally seeks to coordinate, when possible, emergent, urgent and elective health care services. Members are assisted by the UM Program in obtaining transitional care benefits such as transitional care for new Members/covered persons and continuity of coverage for Members/covered persons whose Health Care Providers are no longer participating with the Plan. The UM Program also outlines the responsibility for oversight of entities to whom the Plan delegates Utilization Management functions.

Criteria Availability

The Plan has adopted clinical practice guidelines for use in guiding the treatment of Members, with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The following complete clinical practice guidelines are available upon request by calling the Provider Services Department or by visiting the Provider Center for AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**

Acute Pharyngitis in Children	Hemophilia
Asthma	HIV
Chlamydia	Hypertension
Cholesterol	Immunizations and Screenings
Chronic and Obstructive Pulmonary Disease	Maternity

Diabetes	Preventive Health Guidelines
Heart Failure	Sickle Cell

The Plan will provide its Utilization Management (UM) criteria to Network Providers upon request. To obtain a copy of the Plan UM criteria:

- Call the AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622.**
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within 5 business days of your request.

Please remember that the Plan has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. Call the Peer-to-Peer hotline at **1-877-693-8480.**

Additionally, the Plan would like to remind Health Care Providers of our affirmation statement regarding incentives:

- UM decision-making is based only on appropriateness of care and the service being provided
- The Plan does not reward Health Care Providers or other individuals for issuing denials of coverage or service
- There are no financial incentives for UM decision makers to encourage underutilization

Hours of Operation

A toll free number (AmeriHealth Caritas Pennsylvania's Utilization Management Department at **1-800-521-6622** is available for Providers to contact the Plan's UM staff. The UM Department is available to answer calls during normal business hours, 8:30 a.m. - 5:00pm.

Translation services are available as needed.

After business hours and on weekends and holidays, Health Care Providers are instructed to contact the On-Call Nurse through AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200**. After obtaining key contact and Member information, the Member Service Representative pages the on-call Nurse. The on-call Nurse contacts the Health Care Provider, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse is responsible to contact the requesting Health Care Provider and, when applicable, the Member with the outcome of the request.

Utilization Management Inpatient Stay Monitoring

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

Members with Medicare coverage are not required to have admission authorization. The Plan's referral and authorization requirements are applicable if the services are covered by Medicare and the Member's Medicare benefits have been exhausted.

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

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

Timeliness of Utilization Management Decisions

Several external standards guide the Plan's timeline standards. These include NCQA, DHS HealthChoices standards, Pennsylvania's Act 68 and accompanying regulations, and other applicable state and federal laws and regulations. Where standards conflict, the Plan adopts the more rigorous of the standards. Table 1 identifies the Plan's timeliness standards.

Table 1: Timeliness of Utilization Management Decisions – Excludes Pharmacy

Case Type	Decision	Initial Notification	Written Confirmation*
Urgent Precertification	24 hours from receipt of request**	24 hours from receipt of request	2 business days after decision is made
Non-Urgent Precertification	2 business days from receipt of the request**	2 business days from receipt of the request	2 business days after decision is made

Concurrent Review	1 business day from receipt of the request**	1 business day from receipt of the request	2 business days after decision is made
Retrospective Review***	30 calendar days from receipt of the records	30 calendar days from receipt of the records	2 business days after decision is made
Home Health, Non-Urgent Precertification	48 hours from receipt of request**	48 hours from receipt of request**	2 business days after decision is made

*Written confirmation is provided for all cases where coverage for the requested service is partially or completely denied.

** The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the Member and requesting Health Care Provider are notified of the required information in writing (not applicable to retrospective review).

*** *Retrospective Review requests are to be received no later than 180 days from the date of service*

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

Denial and Appeal Process

Medical necessity denial decisions made by a Medical Director, or other physician designee, are based on the DHS definition of Medically Necessary, in conjunction with the Member's benefits, applicable MA laws and regulations, the Medical Director's medical expertise, medical necessity criteria, as referenced above, and/or published peer-review literature. At the discretion of the Medical Director, in accordance with applicable laws, regulations or other regulatory and accreditation requirements, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Medical Director or physician designee makes the final decision. Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the Member's eligibility changes between the time authorization was issued and the time the service was provided. Upon request of a Member or Network Provider, the criteria used for making Medically Necessary decisions is provided, in writing, by the Medical Director or physician designee.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, the Plan's physician reviewers are available to discuss the decision with the practitioner. A call to discuss the determination is accepted from the Practitioner:

- Within 5 business days of the verbal/faxed denial notification.
- Up to 5 business days after a determination for a Prior (Pre-Service) request has been rendered.
- Up to 5 business days after a determination of a retrospective review has been rendered, whichever is later.

A dedicated reconsideration line with a toll-free number has been established for practitioners to call at **1-877-693-8480.** An intake representative will take your information and communicate it to the physician. The physician will respond the requests within 3 business days. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal. For information on the types of issues that may be the subject of a Formal Provider Appeal, please see Section 7.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, DHS requirements and Department of Health requirements. Denial letters are available in other preferred languages and formats upon request. This service is available through the cooperation of Member Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the Member's rights to appeal and the processes for filing appeals through the Plan Complaint and Grievance Process and the DHS Fair Hearing Process. Members contact the Member Service Unit to file Complaint and Grievance appeals where a Member advocate is available to assist Members as needed.

Evaluation of New Technology

When the Plan receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or DHS technology assessment group guidelines. The Plan Medical Directors make the final determination on coverage.

Evaluation of Member & Provider Satisfaction and Program Effectiveness

Not less than every two years, the Utilization Management department completes an analysis of Member and Network Provider satisfaction with the UM program. At a minimum, the sources of data used in the evaluation include the annual Member satisfaction survey, Member Complaints, Grievances and Fair Hearings, and Provider Network surveys and complaints.

To support its objective to create partnerships with physicians, the Plan actively seeks information about Network Provider satisfaction with its programs on an ongoing basis. In addition to monitoring Health Care Provider complaints, the Plan holds meetings with Network Providers to understand ways to improve the program.

Monthly, the department reports telephone answering response, abandonment rates and decision time frames.

Section 9: Special Healthcare Needs and Care Management

Enhanced Member Supports Unit

The Enhanced Member Supports Unit (EMSU) provides coordination of services to new and existing adult and pediatric Plan Members with short-term, intermittent, and/or long-term needs. The Care Managers in this unit support Members in resolution of pharmacy, DME and/or dental access issues, Health Related Social Needs (HRSN), identification of and access to Specialists, or referral and coordination with behavioral health providers or other community resources. The EMSU staff provide guidance to providers to ensure their patients have the equipment and services they need. There is also a dedicated Care Manager who acts as the point person/liaison to coordinate and collaborate with Behavioral Health MCOs for Members with both physical and behavioral/mental health issues, as well as various government offices, Health Care Providers, and public entities to deal with issues relating to Members with Special Healthcare Needs.

For more information and/ or to refer Members to the EMSU call 1-800-684-5503.

Specialists as PCPs for Members with Special Healthcare Needs

Specialists may be able to serve as PCPs for Members with Special Healthcare Needs, including Members that have a disease or condition that is life threatening, degenerative, or disabling. Plan Members may contact the Enhanced Member Supports Unit (EMSU)to request designation as a "Member with Special Healthcare Needs" and request approval to utilize a specialist as PCP. Care Managers will work with the Member and Plan staff to identify an appropriate Specialist. The Specialist must have expertise in the treatment of the medical condition of the Member.

To accommodate these Members, the Plan's EMSU will contact the requested Specialist and obtain their verbal agreement to provide specialty care services, as well as, primary care services. The Specialist will be informed that the final approval is subject to meeting credentialing requirements and office accessibility standards (including EPSDT). Upon approval, this information will be forwarded to the Provider Network Management and Member Services Departments. The Plan's Provider Network Management Department will negotiate a contract with specialists who meet the Plan's Credentialing criteria, and who wish to function as a PCP for a Member(s) with Special Healthcare Needs. The specialist will be set-up in our Provider Network database as a "Specialist as PCP". The Member will then be assigned to the "Specialist as PCP" panel.

Population Health Management (PHM)

The Care Management program is a population-based health management program that utilizes a blended model that provides comprehensive care management and disease management services and care coordination to the highest risk health plan Members. The primary focus is on coordination of resources for those Members expected to experience adverse events in the future and assisting Members with complex medical needs. The voluntary program provides specialized services which support and assist Members with medical, behavioral and/or social issues that impact their quality of life and health outcomes. Identified issues/diagnoses that would result in a referral to a Care Management program include, but are not limited to:

- Multiple diagnoses (4 or more major diagnoses)
- Pregnancy
- Pediatric Members requiring shift care services
- Members with dual medical and behavioral health needs
- Members with behavioral health diagnoses needing assistance with referral to a Behavioral Health Managed Care Organization (BH-MCO) or special help with access to medical care
- Members with Intellectual Disabilities
- Members with a Special Healthcare Needs
- Members with Chronic Diseases including but not limited to:
    - Heart Failure
    - Diabetes
    - Asthma
    - COPD
    - Sickle Cell
    - HIV
    - Hemophilia

The Care Management programs consist of a multi-faceted approach including telephonic, virtual, texting, and face to face outreach that includes various assessments, and applicable interventions. The team consists of registered nurses, social workers, care connectors (non-clinical), and community health navigators who assist Members in overcoming barriers in achieving their health care goals. The Care Management staff outreach to the Member, and/or Member representative, as indicated, and may collaborate with the PCP and/or Specialist to develop a plan of care.

Complex Care Management

Members identified as high-risk receive targeted education on their disease(s) as well as engagement into our Complex Care Management program. Care Managers and Members set goals and develop a plan of care with input from the physician(s), as indicated. The Complex Care Management component of the PHM program provides coordination of services to pediatric and adult Members with complex health issues– usually with multiple comorbidities/disease states. Members are identified for the program through multiple sources including provider referrals, Member self-referrals and from other internal and external sources. The Complex Care Management program is a holistic approach and evaluates Member's physical, behavioral and Health Related Social Needs (HRSN). The program integrates physical health and psychosocial/environmental aspects of the Member's care into a single plan of care. Members in the program are continually reassessed and needs evaluated to ensure optimal health outcomes.

For more information and/ or to refer Members to the Program call 1-877-693-8271.

Care Coordination

The Care Coordination program coordinates services for Members with short-term, intermittent, and/or long-term needs as well as emerging risks. Care Managers support Members in the resolution of pharmacy, Durable Medical Equipment (DME), discharge and transitional planning needs, dental access issues, HRSN, referrals and access to physical, behavioral healthcare providers, specialists, and community resources. Care Managers perform assessments and address needs through an individualized plan of care, providing ongoing education to Members in an effort to avoid long term complications associated with healthcare needs. **For more information and/ or to refer Members to the Program call 1-877-693-8271.**

Pediatric Shift Care

Pediatric Shift Care Management is provided to Members under 21 years of age who are medically fragile and have chronic health care needs and receive skilled nursing and/or home health aide services. EMSU Care Managers assist with coordination of care to ensure that the needs of the Member are being met. This coordination of services includes providing caregiver education, addressing shift care staffing needs, assisting with the Age Out process for Members 18-21 years old, and addressing any other identified needs.

For more information and/ or to refer Members to the Pediatric Shift Care Management program call 1-800- 684-5503.

The Bright Start® Maternity Program for Pregnant Members

The Bright Start Maternity Program is a focused collaboration designed to improve prenatal care for pregnant Members. The Bright Start Maternity Program assesses, plans, implements, teaches, coordinates, monitors and evaluates options and services required to meet the individual's health needs. Various modes of communication and available resources are utilized to promote quality and cost-effective outcomes. The design of the Bright Start Maternity Program allows for collaboration between the Care Manager, the Member, the Obstetrician, and the BHMCO for assessment and interventions to support management of behavioral/social health issues.

The Bright Start Maternity Program is designed to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program provides focused, collaborative services designed to improve prenatal care for pregnant Members. AmeriHealth Caritas PA developed this comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population.

Program Goals:

- Early identification of pregnant Members
- Facilitate access to needed services and resources
    - Behavioral Health
    - Dental Screenings

- Assess and address healthcare disparities in pregnant women
- Build collaborative relationships with community-based agencies that specialize in home visiting services from pregnancy up to the child's 6th birthday.
- Encourage early prenatal care and continuum of care through post-partum period by increasing awareness through Member education and community alliances
- Improve health outcomes for neonates

Members enrolled in the Bright Start Maternity Program receive a variety of interventions depending upon the assessed risk of their pregnancy. All pregnant members receive educational material about pregnancy, preparing for delivery, and how to access the Bright Start Maternity program for any questions/concerns. Members are triaged into low-risk and high-risk populations by using informatics reports and assessment information provided by the obstetrics practitioner

- Low risk Members are outreached by a care connector, non-clinical staff, who assist with assessing needs, providing resources, and making sure Members attend their prenatal and postpartum appointments.
- High risk Members are followed by Case Managers and registered nurses who support the Member with identifying potential barriers to receiving care, assist with coordination, and encourage health prenatal behavior.

Bright Start Maternity programs designed to positively impact birth outcomes:

- Moms 2B program
- Postpartum visit coordination
- Keys to Your Care texting/rewards program

For more information and program details, visit the dedicated Bright Start Maternity page on the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**. To refer Members to the Bright Start Maternity Program call **1-877-364-6797.**

Postpartum Home Visit Program

Purpose

The Postpartum Home Visit is offered to all Members who deliver a baby. The purpose of the program is to support the Member receiving the appropriate clinical assessment, education and support for a healthy transition from the hospital to home.

- All Members and newborns are able to receive a home visit upon discharge from the hospital.
- All deliveries (vaginal or cesarean) are eligible for home visits.
- If complications are identified during the home visit, it is the responsibility of the Home Visit Provider to request the authorization of additional home visits or other services.
- The Postpartum Home Visit includes a physical, psychosocial and environmental assessment with individualized education, counseling and support.

- Visit timeframe: Complete both visits between 7 through 84 days post-delivery.

Requesting a Postpartum Home Visit

Network Providers should contact their facility's Discharge Planner to request a Postpartum Home Visit for their patient.

Pregnancy, Baby, and Young Child Home Visiting Program

This program is available to all AmeriHealth Caritas PA Members who are pregnant, and/or are parents/caregivers with young children at home, who may be facing difficult health risks or barriers to care.

The goal of the home visiting program:

- Help prepare new Moms with the resources they need to have a healthy transition from hospital to home, and help their newborns have a healthy start to life.
- Provide parents/caregivers with individualized education, counseling and support in order to promote healthy early childhood development.
- Assist in ensuring the safety of the child(ren) and the parents/caregivers in the home.
- Identify any HRSN that need to be addressed, as well as the resources available to do so.
- Encourage, assist, and ensure that both the child(ren) and parent/caregivers have access to appropriate physical and behavioral health follow-up care.

AmeriHealth Caritas PA will provide home visiting services to our Members throughout their entire pregnancy and up to a minimum of18 months of their child's life. Our staff is available to help connect our Members with community-based organizations that provide home visiting programs during that timeframe.

For further information, Members should call our Bright Start Department directly at **1-877-364-6797.**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The goal of the Pediatric Preventive Health Care (PPHC) Program is to improve the health of Members under age 21 by increasing adherence to the Pennsylvania Children's Checkup Program and National Immunization Program guidelines. The PPHC program focuses on identification and coordination of preventive services for Members under age 21.

The program is structured to provide assessment of the Member's condition and monitoring of adherence to pediatric preventive guidelines, along with consideration of the Member's other health conditions and lifestyle issues. The PPHC Program provides a mechanism to ensure that Members under age 21 receive screening, preventive care and related medical services required by the EPSDT program. By state and federal mandate, EPSDT requirements include: well child visits, immunizations, lead screening, dental services, vision screening, hearing screening, anemia

screening, urinalysis, Sickle Cell Disease screening and screening for Sexually Transmitted Diseases (STDs). Members are considered enrolled upon identification, unless the Member or parent/guardian notifies the Plan to remove the Member from the program. Upon enrollment, eligible Members receive program materials explaining how to use the program, available services, how Members are selected to participate and how to opt-out of the program.

Detailed information about the Plan's EPSDT requirements for physicians can be found in the Referral and Authorization Requirements and Policies section of this manual.

Outreach & Health Education Programs

The Plan develops innovative programming in an effort to increase Member health screening compliance in the community setting while also providing disease management/prevention education. The goal of The Plan's Community Health Education Programs is to increase Members' knowledge of self-management skills for selected disease conditions. The health education programs focus on prevention in order to help Members improve their quality of life. The Community Outreach team works in collaboration with the Rapid Response Outreach Team and Care Management units to achieve these desired outcomes.

The AmeriHealth Caritas Pennsylvania Community Outreach Department facilitates baby showers, community gardens, health education programs and participates in community events both as a sponsor and active participant. The department also leads the GED program and Medical Assistance work supports calls assisting and encouraging Members to seek employment and continue their education.

The goal of these initiatives is to address HRSN domains and improve Member outcomes through education while encouraging Members to see their primary care physician.

Member Support through Community Based Care Management (CBCM) programs, and Community Health Workers (CHW)

CBCM programs are community-based programs to support Members, are multifaceted and include statewide and local programs. CBCM programs are intended to:

- Assess, refer and mitigate HRSN;
- Promote maternal, infant and early childhood assessment, education and referral including expansion and capacity building of existing home visiting programs;
- Localize efforts to promote health education and wellness and encourage the use of preventive health services;
- Promote education on the appropriate management of chronic health conditions;
- Enhance behavioral and physical health coordination of services; and
- Reduce healthcare disparities.

CBCM programs span from programs directly addressing HRSN such as, but not limited to homelessness, financial insecurity, and access to healthcare.

The Plan meets regularly with each CBCM program to oversee these programs. These meetings include a liaison from Care Management staff to maintain an open line of communication from the program to the plans resources as needed.

Many CBCM programs include CHW's specially trained staff with lived experience that live in and connect with our Members in their communities.

Providers may learn about our CBCM programs, including, but not limited to, the following methods:

- Flyers describing the programs
- Provider webinars, such as PCP, OB/GYN, Patient Centered Medical Homes (PCMH), etc.
- Provider Quality and PCMH in-person meetings

Providers may refer Members to a CBCM program through the Provider Let Us Know program. For details, refer to the Let Us Know section of the manual.

Rapid Response and Outreach Team (RROT)

Rapid Response and Outreach Team (RROT) is a department that provides short-term and episodic outreach and support to our Members. We resolve immediate and urgent Member needs, help make sure Members are matched with a health care provider, connect them with available community services.

Our goals include identifying and eliminating barriers to full participation in treatment, identifying and resolving health related social needs, and advocating for the Member to maximize their use of available resources benefits and serve as a front line referral source to case management.The RROT can assist Members:

- Schedule doctor appointments.
- Help with transportation concerns.
- Help Members with HRSN.
- Help remove barriers to health care services.
- Answer questions about how to get medicine, supplies and medical equipment.
- Find resources in the community (dental, vision, behavioral health, housing, food and clothing).
- Call Members after a stay in the hospital to make sure the services they need (such as therapy and home health care) have been set up.

There are four key service functions performed:

1. **Inbound Call Service**. Members and Plan providers may request RROT support via a direct, toll-free Rapid Response line at **1-800-684-5503**. Referrals to RROT are also received through many sources, such as the EMSU, Member Services, Pharmacy, Utilization Management and Provider Relations.
2. **Outreach Service.** Outreach activities include telephonic survey or assessment completion and support of special projects or Quality initiatives. RROT associates also place outreach

follow-up calls to those Members who have called the 24 hour Nurse Line, ER discharges, missing gaps in care, assistance needed with HRSNand require further assistance from Care Management staff.

3. **Clinical and Non-Clinical Care Management Support.** Care Coordinators support Care Managers in Care Coordination by providing administrative support to Members. These include appointment scheduling and reminders, transportation support, Member educational mailings, and other administrative tasks assigned by Care Managers.
4. **Support EPSDT** (Early Periodic Screening Diagnostic and Treatment) services. EPSDT services are mandated by Federal and State contracts to ensure that children enrolled in Medicaid receive preventive health services before a condition becomes serious to impair their growth and development. Care Connectors are trained to assist parents/guardians in getting access to routine check-ups, mandatory periodic examinations and evaluations which are helpful to assess, control, correct or reduce health problems identified.

Let Us Know Program

The Let Us Know program is administered through the Integrated Care Management (ICM) department and is a partnership between the Plan and the provider community. This program was designed to assist providers in the engagement and management of chronically ill Members. The program supports providers in the identification, outreach and education of Members for such issues as inappropriate use of emergency room, not showing up for appointments, non-compliance with prescribed medications, assistance needed with HRSN and much more.

There are two ways to alert the Let Us Know Program:

1. Refer a patient to the AmeriHealth Caritas Pennsylvania Integrated Care Management Program at **1-877-693-8271.**
2. Contact the AmeriHealth Caritas Pennsylvania Rapid Response Unit at **1-800-684-5503, press #8 for Providers,** from 8:00 a.m. until 5:00 p.m. or fax a Member intervention request form to **1-717-651-1673**. The form can be found on the Let Us Know section of the Provider Center at the AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com**.

Tobacco Cessation

Tobacco cessation assistance is available to Members through medications or counseling services. The statewide PDL identifies medications covered. Counseling support may also help Members to quit smoking. All Members are eligible for 70 counseling sessions per calendar year. Each session is a 15-minute, face-to-face counseling session, for either group or individual counseling and no referral or pre-approval is required. The counselor must be a part of the Medical Assistance program and approved by the Department of Health.

Additional assistance is available through the PA Department of Health PA Free Quitline program and information can be located here:

https://www.health.pa.gov/topics/programs/tobacco/pages/quitline.aspx

Domestic Violence Intervention

There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health Care Providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables Health Care Providers to assist their patients, and family members who are victims.

The clinical model known as RADAR was developed by the Massachusetts Medical Society to assist clinicians in addressing domestic violence and is an excellent tool for assisting Health Care Providers in the identification of and intervention with possible domestic violence victims.

The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

Routinely screen about partner violence.

Ask directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview the patient in private at all times.

Document information about "suspected domestic violence" or "partner violence" in the patient's chart.

Assess the patient's safety. Is it safe for her to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

Review options with the patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

You can help your patients by referring them to **www.ndvh.org** or have them contact the National Domestic Violence Hotline, where all calls are free and confidential.

National Domestic Violence Hotline

1-800-799-7233 (SAFE)

1-800-787-3224 (TTY for the Deaf)

*Help is available in English, Spanish and many other preferred languages.

Pennsylvania Coalition Against Domestic Violence

The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

Call **1-717-545-6400** (in Pennsylvania)

The Provider's Role

Network Providers can help to identify and refer Members who are at high risk for particular diseases and disorders to the appropriate program.

Call the Outreach & Health Education Program Staff at **1-800-521-6007**:

- With questions about any of the health education programs
- With requests for outreach services

Pennsylvania's Early Intervention System

Early Intervention Services*

While all children grow and develop in unique ways, some children experience delays in their development. Children in Pennsylvania with developmental delays benefit from a state supported collaboration among parents, service practitioners and others who work with young children needing special services. The Pennsylvania Early Intervention program provides support and services to families with children birth to age 5 with developmental delays. Early Intervention builds upon the natural learning opportunities that occur within the daily routines of a child and their family.

Early Intervention promotes a philosophy that supports:

- Services and resources for children that enhance daily opportunities for learning provided in settings where a child would be if he/she did not have a disability.
- Families' independence and competencies.
- Respect of families' strengths, values and diversity.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

*Source – **https://www.dhs.pa.gov/Services/Children/Pages/Early-Intervention-Services.aspx**

What children are eligible?

Children from birth to age 5 who have Special Healthcare Needs due to developmental delays or disabilities are eligible to receive Early Intervention services.

What Services are provided to meet the developmental needs of a child?

The services provided to children and their families differ based upon the individual needs and strengths of each child and the child's family. Services such as parent education, support services, developmental therapies and other family-centered services that assist in child development may be included in a family's Early Intervention program.

Early Intervention promotes collaboration among parents, service providers and other important people in the child's life to enhance the child's development and support the needs of the family.

Where do children and their families receive services?

Services may be provided in the child's home, child care center, nursery school, play group, Head Start program, early childhood special education classroom or other settings familiar to the family. Early Intervention provides supports and services in a variety of settings at no cost to the family. Early Intervention supports and services are embedded in typical routines and activities, within the family, community and/or early care and education settings. This approach provides frequent, meaningful practice and skill building opportunities.

Parents who have questions about their child's development may contact the **CONNECT Helpline** at **1-800-692-7288**. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children ages birth to age 5. In addition, CONNECT can assist parents by making a direct link to their local Early Intervention program or local preschool Early Intervention program.

Referrals to Early Intervention are directed to the local Early Intervention service coordination unit. Initial contact with the referred family occurs locally and at a time and place convenient to the family.

Section 10: Member Rights and Responsibilities

Member Rights & Responsibilities

The Plan 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. Plan Members have the following rights and responsibilities. Providers can obtain Member Rights and Responsibilities on **www.amerihealthcaritaspa.com**

Member Rights

Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by Plan 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 the Plan, 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 the Plan's approval.
- To get information that they can easily understand and talk to their providers about their treatment options, risks of treatment, and tests that may be self-administered without any interference from the Plan.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.
- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to their records.
- To ask for a second opinion.
- To file a Grievance if they disagree with the Plan's decision that a service is not medically necessary for them.
- To file a Complaint if they are unhappy about the care or treatment they have received.
- To ask for a Department of Human Services (DHS) Fair Hearing.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.
- To get information about services that the Plan 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, the Plan, and network providers treat them.
- To create an advance directive. Members can see their Member Handbook for more information.
- To make recommendations about the rights and responsibilities of the Plan's Members.
- To know and get information about:

    - The Plan and its health care providers.
    - Their Member rights and responsibilities.
    - Their benefits and services.
    - The cost of health care.
- To talk with their health care provider about:
    - Their treatment plans, regardless of cost or benefit coverage.
    - The kinds of care they can choose to meet their medical needs, in a way they understand.
- To take an active part in the decisions about their health care, including the right to refuse treatment. Their decision to do so will not negatively affect the way they are treated by the Plan, its health care providers, or DHS.
- To voice complaints about and/or appeal decisions made by the Plan and its health care providers.
- To be given an opportunity to make suggestions for changes in Plan policies and procedures.

Member Responsibilities

Members need to work with their health care service providers. AmeriHealth Caritas Pennsylvania needs Members' help so that they get the services and supports they need.

These are the things Members should do:

- Provide, to the extent they can, information needed by their providers.
- Follow instructions and guidelines given by their providers.
- Be involved in decisions about their health care and treatment.
- Work with their providers to create and carry out their treatment plans.
- Tell their providers what they want and need.
- Learn about Plan coverage, including all covered and non-covered benefits and limits.
- Use only network providers unless the Plan approves an out-of-network provider or they have Medicare.
- Be referred by their primary care provider (PCP) to see a specialist.
- Respect other patients, provider staff, and provider workers.
- Make a good-faith effort to pay their co-payments.
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.
- Let the Plan and their health care providers know of any changes that may affect their membership, health care needs, or benefits. Some examples include, but are not limited to, the following:
    - They are pregnant.
    - They have a new baby.
    - Their address or phone number changes.
    - They or 1 of their children have other health insurance.
    - They have a special medical condition.
    - They change their PCP.

    - Their family size changes.
    - They move out of the county or state that they live in now.
- Work with the Plan and our health care providers. This means they should follow the guidelines given to them about the Plan and they should follow their health care provider's instructions about their care. This includes:
    - Making appointments with their health care provider.
    - Canceling appointments when they cannot make their appointments.
    - Calling the Plan when they have questions.
- Talk with their health care provider to agree on goals for their treatment, to the degree they are able to do so.
- Talk with their health care provider so they can understand their health problems, to the degree they are able to do so.

Members have the responsibility to treat their Network Provider and the Network Provider's staff with respect and dignity.

Patient Self-Determination Act

The Patient Self-Determination Act is a Federal law recognized in the Commonwealth of Pennsylvania. It states that competent adults have the right to choose medical care and treatment. A Member has the right to make these wishes known to his/her PCP and other Providers as to whether he/she would accept, reject or discontinue care under certain circumstances.

A Member should prepare an advance directive to maintain his/her rights in a situation where he/she may not be able to tell his/her Health Care Provider what is/is not wanted. Once the Member has prepared an advance directive, a copy should be given to his/her PCP. The Health Care Provider should be aware of and maintain in the Member's medical record a copy of the Member's completed advance directive. Members are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive.

An **Advance Directive** is only used when the Member is not able to make decisions about his/her treatment, such as if the Member is in a coma.

There are two kinds of documents that can act as an advance directive in the Commonwealth of Pennsylvania:

Living Will

A living will is a written record of how the Member wishes his/her life to be sustained in the event he/she is unable to communicate with a Health Care Provider. This document should outline the type of treatments the Member would or would not want to receive.

Durable Health Care Power of Attorney

This legal document names the person the Member assigns to make medical treatment decisions for him/her in case he/she cannot make them for himself/herself. This person does not have to be an attorney.

If Members have questions about the Patient Self-Determination Act and to Member Services at **1-888-991-7200.**

Section 11: Regulatory Provisions

Access to & Financial Responsibility for Services

Member's Financial Responsibilities

Network Providers and other Providers may not deny a covered service because a Member is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

If the Plan notifies the Health Care Provider and/or the Member that a service will not be covered, and the Member chooses to receive that service or treatment, the Member can be billed for such services. The Plan Members may be directly billed for non-covered services provided they have been informed of their financial responsibility prior to the time services are rendered. The Member's informed consent to be billed for services must be documented. It is suggested that the Health Care Provider obtain a signed statement of understanding of financial responsibility from the Member **prior to rendering services**.

As outlined in the Pennsylvania Department of Human Services' Medical Assistance bulletin 99-99-06 entitled "Payment in Full", the Plan strongly reminds all providers of the following point from the bulletin:

Providers requiring Medicaid recipients to make cash payment for Medicaid covered services* or refusal to provide medically necessary services to a Medicaid recipient for lack of pre-payment for such services are illegal and contrary to the participation requirements of the Pennsylvania Medical Assistance program.

***Covered services include products, office visits, urine drug screens, counseling referrals, etc., used to treat opioid dependence.**

Additionally the Pennsylvania Code, 55 Pa. Code § 1101.63 (a) statement of policy regarding full reimbursement for covered services rendered specifically mandates that:

- All payments made to providers under the MA program plus any copayment required to be paid by a recipient shall constitute full reimbursement to the provider for covered services rendered.
- A provider who seeks or accepts supplementary payment of another kind from the Department, the recipient or another person for a compensable service or item is required to return the supplementary payment.

To review the complete MA Bulletin 99-99-06, "Payment in Full", visit the Provider Center at **www.amerihealthcaritaspa.com → Providers → Communications → DHS/Medical Assistance Bulletins**.

Services Provided by a Non-Participating Provider

The Plan's Provider Services Department will make every effort to arrange for the Member to receive all necessary medical services within the Plan's Network of Providers in collaboration with the recommendations of the PCP. Occasionally, a Member's health care needs cannot be met through the Plan's Network of Providers. All services by Non-Participating Providers (except Emergency Services, Family Planning Services through the Plan, and Medicare covered services by a

Medicare Health Care Provider) require Prior Authorization from the Plan's Utilization Management Department. Unauthorized services rendered by Non-Participating Providers are not compensable and may become the financial responsibility of the Plan Member if the Member chooses to receive services or treatment by the Non-Participating Provider.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), all providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This does not apply to non-participating out-of-state Providers under single case agreements.

DHS may make a determination that adopts the encounter limits or thresholds that would require the non-participating out-of-state providers to convert to in-network status, which would require enrollment in the Pennsylvania Medical Assistance Program.

Additionally, all providers, including those who order, refer or prescribe items or services for The Plan's Members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02 and 99-18-06) outlining all requirements can be accessed on the Plan's Provider website at **www.amerihealthcaritaspa.com** → **Providers** → **Communications** → **DHS/Medical Assistance Bulletins**.

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

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

Services Provided Without Required Referral/Authorization

Except for certain services, and Network Providers for which specific prepayment arrangements have been made, e.g., lab services and certain PCP services, The Plan requires Prior Authorization of certain health care treatment and services rendered to its Members. Health Care Providers should refer to Section 2 of the Manual titled "Referral and Authorization Requirements" for this information. Members should also be referred to the Member Handbook for a listing of those services that require a referral or Prior Authorization. The Plan is not obligated to provide reimbursement for services that have not been appropriately authorized.

Services Not Covered by the Plan

The Plan is a Pennsylvania Medical Assistance Managed Care Organization, and as such, has a benefit structure that closely resembles the Pennsylvania Medical Assistance fee-for-service program. The Plan is not responsible for reimbursing for services, treatments, or other items that

are outside of the covered benefit structure of the Plan. If the Plan notifies the Health Care Provider and/or the Member that a service will not be covered, and the Member chooses to receive that service or treatment, the Member can be billed by the Health Care Provider for such services provided that the Member has been informed of his/her financial responsibility prior to the time services are rendered. Health Care Providers should refer to Section 1 of the Manual titled "Member Co-Payment Schedule" or call AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** with questions about covered/non-covered services. Members should also be referred to the Plan's Member Handbook or speak with AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200** when questions arise about services that are or are not covered by the Plan.

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

Member Accessibility to Providers for Emergency Care

No Prior Authorization for Emergency Services

The Plan does not require Prior Authorization or pre-approval of any Emergency Services.

The Plan PCP and Specialist Office Standards (see Section 6 of this Manual) require Network Providers to provide Medically Necessary covered services to Plan Members, including emergency and/or consultative specialty care services, 24 hours a day, 7 days a week. Members may contact their PCP for initial assessment of medical emergencies.

In cases where Emergency Services are needed, Members are advised to go to the nearest Hospital Emergency Room (ER), where ER staff should immediately screen all Plan Members and provide appropriate stabilization and/or treatment services.

Care Out of Service Area

Plan Members have access to Emergency Services when traveling anywhere in the United States. Although not required, Members are encouraged to contact their PCP to report any out-of-area Emergency Services received.

The Plan is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) that all providers, including those who order, refer or prescribe items or services for The Plan's Members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02 and 99-18-06) outlining all requirements can be accessed on the Plan's Provider website at **www.amerihealthcaritaspa.com → Providers → Communications → DHS/Medical Assistance Bulletins**.

The Plan will use the NPI of the ordering, referring or prescribing provider included on the rendering provider's claim to validate the provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering provider will be denied if it is submitted without the

ordering/prescribing/referring provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA provider.

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

Compliance with the HIPAA Privacy Regulations

In addition to maintaining the Corporate Confidentiality Policy, the Plan is required to comply with the Privacy Regulations as specified under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

AmeriHealth Caritas Pennsylvania complies with all provisions stipulated in the HIPAA Privacy Regulations, including, but not limited to, the following:

- Designated a Privacy Officer who is responsible for the directing of on-going activities related to the Plan's programs and practices addressing the privacy of Member's protected health information (PHI).
- Developed a centralized Privacy Office, which is responsible for the day-to-day oversight and support of Privacy-related initiatives conducted at the Plan.
- Issues copies of the Plan's Notice of Privacy Practices to the recently enrolled and existing membership of the health plan, which describes how medical information is used and disclosed, as well as how it can be accessed.
- Established and/or enhanced processes for our Members to exercise their rights under these regulations, such as requesting access to their PHI, or complaining about the Plan's privacy practices.

Allowed Activities under the HIPAA Privacy Regulations

The HIPAA Privacy Regulations allow covered entities, including Health Care Providers and health plans the ability to use or disclose PHI about its Members for the purposes of Treatment, Payment and/or Health plan Operations (TPO) without a Member's consent or authorization. This includes access to a Member's medical records when necessary and appropriate.

"TPO" allows a Health Care Provider and/or the Plan to share Members' PHI without consent or authorization by establishing these purposes as follows:

"Treatment" includes the provision, coordination, management, consultation, and referral of a Member between and among Health Care Providers.

Activities that fall within the "**Payment"** category include, but are not limited to:

- Determination of Member eligibility;
- Reviewing health care services for medical necessity and utilization review;
- Review of various activities of Health Care Providers for payment or reimbursement to fulfill the Plan's coverage responsibilities and provide appropriate benefits;

- To obtain or provide reimbursement for health care services delivered to Members.

"Operations" includes:

- Certain quality improvement activities such as Care Management and care coordination;
- Quality of care reviews in response to Member or state/federal queries;
- Response to Member Complaints/Grievances;
- Site visits as part of credentialing and recredentialing;
- Administrative and financial operations such as conducting Health Plan Employer Data And Information Set (HEDIS) reviews;
- Member services activities;
- Legal activities such as audit programs, including fraud and abuse detection to assess conformance with compliance programs.

While there are other purposes under the Privacy Regulations for which the Plan and/or a Health Care Provider might need to use or disclose a Member's PHI, TPO covers a broad range of information sharing.

For more information on HIPAA and/or the Privacy Regulation, please visit the Provider Center at AmeriHealth Caritas Pennsylvania Provider Center at **www.amerihealthcaritaspa.com** and click on the HIPAA Page or contact AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007.**

Contact Information

Listed below are general contact addresses for accessing the Plan, DHS, and other related organizations. For information about additional organizations, contact AmeriHealth Caritas Pennsylvania's Provider Services Department at **1-800-521-6007** or AmeriHealth Caritas Pennsylvania's Member Services Department at **1-888-991-7200**.

AmeriHealth Caritas Pennsylvania
8040 Carlson Road, Suite 500
Harrisburg, PA 17112

Department of Human Services
Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, PA 17105

Pennsylvania Health Law Project
123 Chestnut St, Suite 400
Philadelphia, PA 19106
Phone: **1-215-625-3990**
Fax: **1-717-236-6311**

Toll free line: **1-800-274-3258**
TTY line: **1-866-236-6310**
Email at **staff@phlp.org**.

Disabilities Law Project
The Philadelphia Building
1315 Walnut St., Suite 400
Philadelphia, PA 19107-4798
1-215-238-8070 (Voice)
1-215-789-2498 (TDD)
1-215-772-3126 (Fax)

Office of Maternal & Child Health
1101 Market Street
9th Floor
Philadelphia, PA 19107
1-215-685-5225
1-215-685-5257 (Fax)

Cultural Responsiveness

Cultural Competency, as defined by the Pennsylvania Department of Human Services (DHS), is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

In addition, the US Department of Health and Human Service's Office of Minority Health defines **Cultural Humility** as a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them.

Further, Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In addition, Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health care based on race, color, national origin, sex (includes gender identity and sexual orientation), age, disability in health programs and activities receiving federal funds.

Discriminatory actions against those of Limited English Proficiency (LEP), Low Literacy Proficiency (LLP) or sensory impairment can be seen as discrimination on the basis of national origin.

Therefore, these Medical Assistance recipients must be allotted equal access to all services and benefits of the Plan.

Recipients of federal financial assistance would include the Pennsylvania Medical Assistance Program, and by extension, Medical Assistance Managed Care Organizations, i.e., the Plan and its Network Providers.

As a participant in the Pennsylvania Medical Assistance program, all participating practitioners and other health care providers must take reasonable steps to provide meaningful access to language service assistance as defined by this section of the Civil Rights Act of 1964. Language services include verbal interpreter services and written translation services in Member's preferred language or formats.

In order to be in compliance with federal law and state contractual requirements, the Plan and its Network Providers have an obligation to provide language services to LEP and LLP Members and to make reasonable efforts to accommodate Members with other sensory impairments.

If a Plan Member requires or requests translation services because he/she is either non-English speaking, or of LEP, or of LLP, or if the Member has some other sensory impairment, the Health Care Provider has a responsibility to make arrangements to procure translation services for those Members, and to facilitate the provision of health care services to such Members.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as Health Care Providers) must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/ Health Care Provider relationship.

Providers are required to:

- Provide written and oral language assistance at no cost to Plan Members with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request.
- Make available auxiliary aids and services, such as alternative formats and sign language interpreters, free of charge, when necessary for effective communication.
- Provide Members verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read Member signage and materials in the languages of the common ethnic groups in the Provider's service area. Post statements that language services are available in the top 15 non-English languages spoken in Pennsylvania*

- Vital documents, such as patient information forms and treatment consent forms, must be made available in Member's preferred language and formats.
- Use top 15-language taglines in large-sized communications, such as outreach publication or written notices.*
- Discourage Members from using family or friends as oral translators.
- Advise Members that translation services are available through the Plan if the Provider is not able to procure necessary translations services for a Member.
- Display notice of individual's rights that includes information about LEP communication help.
- *As determined by DHS, the top 15 written non-English languages in Pennsylvania are:
    - Spanish
    - Russian
    - Ukranian
    - Chinese - Mandarin
    - Portuguese
    - Korean
    - Arabic
    - Cambodian
    - Gujarati
    - Nepali
    - Bengali
    - Vietnamese
    - French
    - Haitian Creole

Chinese; Catonese**For complete details, guidelines and the Taglines Representing the Top Fifteen (15) Non-English Languages in Pennsylvania attachment, refer to PA DHS MA Bulletin 99-25-01 on the Provider Center at www.amerihealthcaritaspa.com**. The tagline attachment is also available on the Cultural Competency section on the Provider Center at **www.amerihealthcaritaspa.com → Providers → Initiatives → Cultural competency**.

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a Member has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

- **Therefore if a Plan Member requires interpretation or translation services, the Health Care Provider has a responsibility to provide these services for such Members and ensure culturally appropriate health care services to such Members.**

The Plan contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating Network Providers. For information on using the telephonic interpreter service, visit the Cultural competency page at **www.amerihealthcaritaspa.com → Providers → Initiatives → Cultural competency** or contact Provider Services at **1-800-521-6007.**

Additionally under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all Members in a manner compatible with the Member's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for Plan Members upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all Member medical records.

We have a dedicated Cultural Responsiveness webpage with multiple resources and training opportunities that address subjects such as: Cultural Humility, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Cultural Responsiveness Training, Servicing Members with LEP and best practices when using language services. They can be accessed on the AmeriHealth Caritas Pennsylvania Provider website at **www.amerihealthcaritaspa.com → Providers → Initiatives → Cultural competency**.

The Plan has a Cultural Responsiveness Plan. Providers may request a copy by contacting Provider Services at **1-800-521-6007**.

The Plan's Corporate Confidentiality Policy

The policy states that during the course of business operations, Confidential Information and/or Proprietary Information, including Member Protected Health Information (PHI), may become available to Plan Associates, Consultants and Contractors. The Plan's use and disclosure of Member PHI is regulated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. The Plan's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the confidentiality and disclosure of health information.

The Plan is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of Member PHI, in compliance with all applicable laws and regulations. It is the obligation of all Plan Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of the Plan's Confidentiality Policy and other Plan policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, will be handled on a need-to-know basis. The Plan's Confidentiality Policy and other Plan policies and procedures are adopted to protect the confidentiality of such information consistent with the need to effectively conduct

business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality through the use of aggregated data wherever possible.

No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to the Plan or a Member to any other Associate, Consultant or Contractor unless such a disclosure is consistent with the Plan's Confidentiality Policy.

Both during and after an Associate's association with the Plan, it shall be a violation of the Plan's Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with the Plan or as otherwise required by law. It is also a violation of the Plan's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of the Plan. To the extent that a violation of the Plan's Confidentiality Policy occurs, the Plan reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the Plan's Confidentiality Policy will subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within the Plan.

Confidential information and proprietary information includes, but is not limited to the following:

- Protected Health Information;
- Medical or personal information pertaining to Associates of the Plan and/or its Customers;
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, Members, and/or Customers;
- Information that the Plan is required by law, regulation, agreement or policy to maintain as confidential;
- Financial information regarding the Company, its Members, Network Providers and Customers, including but not limited to contract rates and fees;
- Associate personnel and payroll records;
- Information, ideas, or data developed or obtained by the Plan, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, Health Care Provider payment rates, business of the Plan and/or its Customers;
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of the Plan and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs;
- Information concerning the Plan's business plans;
- Information that could help others commit fraud or sabotage or misuse the Plan's products or services.

Procedure

1. Associates, Consultants and Contractors may use Confidential or Proprietary Information and may disclose Confidential or Proprietary Information internally within the Plan only as necessary to fulfill the responsibilities of their respective position.
2. Confidential Information which is specific to an Associate or Health Care Provider may not be released by the Plan to another party, except as permitted or required by law or regulation, without first obtaining the written consent of that individual. PHI may not be disclosed, other than as permitted or required by law or regulation, or for purposes of treatment, payment or health care operations, without first obtaining a written Authorization as required by HIPAA, or other form of consent as may be required by state law. If an individual is unable to make his/her own decision regarding consent, a legal guardian or other legally authorized representative must provide written consent or an Authorization on the individual's behalf.
3. Associates, Consultants or Contractors, may not disclose Confidential or Proprietary Information to persons or organizations outside the Plan, unless otherwise required by law or regulation or approved by the Legal Affairs Department. Associates, Consultants or Contractors may not make any direct or indirect communication of any kind with the press or any other media about the business of the Plan without express written approval from the Communications Department.
4. Information that pertains to the Plan's operations may be disclosed to the Plan's general partners, Independence Blue Cross and Blue Cross Blue Shield of Michigan, on a need to know basis; provided, however, that Confidential Information and Proprietary Information belonging or pertaining to a Customer may be disclosed ONLY to representatives of that Customer.
5. Any Associate, Consultant or Contractor who is approached with an offer of Confidential Information including PHI or Proprietary Information to which he/she should not have access and/or which was improperly obtained must immediately discuss the matter with his/her supervisor, an attorney in the Legal Affairs Department, the Chief Compliance Officer or the Internal Auditor.
6. All Associates, Consultants and Contractors must review and familiarize themselves with all departmental or any other Plan policies and procedures applicable to confidentiality issues arising within the course of performing their job duties.
7. Each Associate's, Consultant's, and Contractor's level of access to the information maintained in the Plan's computer system is determined by the Information Services Department, based upon the individual's department and job duties. Associates are to access and distribute data electronically only in accordance with instructions given by the Information Services or the Corporate Compliance departments. All Associates, Consultants and Contractors are required to comply with the Information Services policies and procedures regarding security and access to data, electronic mail and other information systems.

8. Associates, Consultants and Contractors must also follow reasonable confidentiality restrictions imposed by previous employers and not use or share that employer's confidential information with the Plan.
9. All Consultants/Contractors, including those who are members of Plan committees, will sign a confidentiality and non-disclosure agreement for the protection of Confidential Information and Proprietary Information.
10. All agreements with Network Providers, Consultants and Contractors will include confidentiality provisions that are consistent with this Policy and Procedure and that require, at a minimum, that the Provider/Subcontractor comply with all federal and state statutes and regulations regarding the disclosure of Confidential Information and otherwise maintain the Plan's Confidential Information and Proprietary Information as confidential. The material elements of this policy and procedure will be communicated to participating Network Providers via the Plan's Network Provider agreements and Network Provider manuals. To the extent that a Health Care Provider, Consultant or Contractor is a Business Associate pursuant to HIPAA, such Health Care Provider, Consultant or Contractor must execute a Business Associate agreement governing the Business Associate's use and disclosure of Protected Health Information as required by HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act.
11. The Legal Affairs and/or Corporate Compliance Department should be contacted whenever issues of confidentiality and/or disclosure of Confidential Information or Proprietary Information arise which are not clearly addressed in the Plan's Confidentiality Policy or other Plan policies and procedures.
12. The Chief Compliance Officer will report to the Compliance and Privacy Committee, all Member, Health Care Provider and Associate complaints regarding confidentiality as well as the resolution of such complaints. The Compliance and Privacy Committee will determine if operational practices should be altered to prevent or reduce the risk of future concerns.

Provider Protections

The Plan shall not exclude, discriminate against or penalize any Health Care Provider for its refusal to allow, perform, participate in or refer for health care services, when the refusal of the Health Care Provider is based on moral or religious grounds. The Health Care Provider must make information available to Members, prospective Members and the Plan about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to Plan Members, due to religious or moral grounds.

Health Care Providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. The Plan will not engage in or condone any such discriminatory practices.

The Plan shall not discriminate against or exclude from the Plan's Provider Network any Health Care Provider because the Health Care Provider advocated on behalf of a Member in a Utilization Management appeal or another dispute with the Plan over appropriate medical care, or because the Health Care Provider filed an appeal on behalf of a Plan Member.

The Plan does not have policies that restrict or prohibit open discussion between Health Care Providers and Plan Members regarding treatment options and alternatives. The Plan encourages open communication between Health Care Providers and our Members with regard to all treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

Section 12: Medical Assistance Manual & Regulatory Provisions

The Plan is providing links to the Medical Assistance Manual regulatory provisions so that Network Providers always have the most current regulatory requirements. Below are links to each section of Chapter 1101 (General Provisions) of the Medical Assistance Manual. You should consult an official publication or reporting service if you want to be assured you have the most up-to-date version of these regulations.

Medical Assistance Manual

Chapter 1101. General Provisions

Preliminary Provisions

1101.11. General provisions.

Definitions

1101.21. Definitions.

Benefits

1101.31. Scope.

1101.31a. [Reserved].

1101.32. Coverage variations.

1101.33. Recipient eligibility.

Participation

1101.41. Provider participation and registration of shared health facilities.

1101.42. Prerequisites for participation.

1101.42a. Policy clarification regarding physician licensure—statement of policy.

1101.42b. Certificate of Need requirement for participation—statement of policy.

1101.43. Enrollment and ownership reporting requirements.

Responsibilities

1101.51. Ongoing responsibilities of Providers.

Fees and Payments

Administrative Procedures

Violations

1101.91 Recipient misutilization and abuse.

1101.92 Recipient prohibited acts, criminal penalties and civil penalties

1101.93 Restitution by recipient

1101.94 Recipient right of appeal

1101.95 Conflicts between general and specific provisions

Medical Assistance Regulations

Below are links to the remainder of the Department of Human Services' Medical Assistance Regulations including the regulations pertaining to specific Provider types.

http://www.pacode.com/secure/data/055/partIIItoc.html

Links are to:

Reporting Communicable and Nonncommunicable Diseases (Chapter 27)

MA Program Payment Policies (Chapter 1150)

Ambulance Transportation (Chapter 1245)

Ambulatory Surgical Center Services and Hospital Short Procedure Unit Services (Chapter 1126)

Certified Registered Nurse Practitioner Services (Chapter 1144)

Chiropractors' Services (Chapter 1145)

Clinic and Emergency Room Services (Chapter 1221)

Dentists' Services (Chapter 1149)

Early and Periodic Screening, Diagnosis and Treatment Program (Chapter 1241)

Family Planning Clinic Services (Chapter 1225)

Funeral Directors' Services (Chapter 1251)

General Provisions (Chapter 1101)

Health Maintenance Organization Services (Chapter 1229)

Healthy Beginnings Plus Program (Chapter 1140)

Home Health Agency Services (Chapter 1249)

Hospice Services (Chapter 1130)

Inpatient Hospital Services (Chapter 1163)

Inpatient Psychiatric Services (Chapter 1151)

Medical Supplies (Chapter 1123)

Midwives' Services (Chapter 1142)

Nursing Facility Care (Chapter 1181)

Nursing Facility Services (Chapter 1187)

Optometrists' Services (Chapter 1147)

Outpatient Drug and Alcohol Clinic Services (Chapter 1223)

Outpatient Laboratory Services (Chapter 1243)

Outpatient Psychiatric Services (Chapter 1153)

Pharmaceutical Services (Chapter 1121)

Physicians' Services (Chapter 1141)

Podiatrists' Services (Chapter 1143)

Portable X-ray Services (Chapter 1230)

Renal Dialysis Services (Chapter 1128)

Rural Health Clinic Services (Chapter 1129)

Shared Health Facilities (Chapter 1102)

Targeted Case Management Services (Chapter 1247)

Section 13: Appendix

Forms and Information available on www.amerihealthcaritaspa.com

1. Hospital Notification of Emergent Admissions form
2. DHS MA-112 Newborn form
3. J&B Medical Supply Incontinence Supply Prescription form
4. EPSDT Physician's Desk Guide
5. PA EPSDT Periodicity Schedule and Coding Matrix
6. CDC Recommended Childhood Immunization and Catch-up Schedule
7. Requirements and Resources for Structured Screening and Developmental Delays and Autism Spectrum Disorder
8. Pharmacy Prior Authorization Form (for a complete listing of Drug-Specific Order forms, please visit AmeriHealth Caritas Pennsylvania at **www.amerihealthcaritaspa.com**)
9. Observation Billing Guidelines
10. CMS Hospital Acquired Conditions
11. MA Bulletin 99-10-14 Missed Appointments
12. Provider Reference Guide
13. Provider Change form
14. Enrollee Consent Form for Physicians Filing a Grievance on behalf of a Member.
15. Domestic Violence –Resources for Patients
16. Claims Filing Instructions
17. Sterilization Consent form (MA31)
18. The Patient Acknowledgement for Hysterectomy (MA 30)
19. Physician Certification for Abortion (MA3)
20. Recipient Statement form (MA368 and MA369)
21. Provider Claim Refund form
22. Pregnant Patients Seeking Dental Care Form (PDF)
23. Chiropractic Evaluation and Treatment Request (PDF)
24. Discharge Planning Form (PDF)
25. Enrollee Consent Form for Physicians Filing Grievance on behalf of the member (PDF)
26. Eneteral Request (PDF)
27. Enviromental Lead Investigations (ELI) Form (PDF)
28. Genetic Request (PDF)
29. Mini Nutritional Assessment (PDF)
30. OB Delivery Log (PDF)
31. Outpatient Therapy/Cardiac and Pulmonary Rehab Request (PDF)
32. Pain Management Injection Request (PDF)
33. Pennsylvania Application For Benefits (PDF)
34. Pennsylvania WIC Program (PDF)
35. Prior Authorization Request (PDF)