<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong></td>
</tr>
<tr>
<td>About the Plan/s</td>
</tr>
<tr>
<td>• Who We Are</td>
</tr>
<tr>
<td>• Our Mission</td>
</tr>
<tr>
<td>• Our Values</td>
</tr>
<tr>
<td>Important Contact Numbers</td>
</tr>
<tr>
<td><strong>Section 1: Covered Benefits</strong></td>
</tr>
<tr>
<td>Services Not Covered</td>
</tr>
<tr>
<td>Benefit Limit and Co-Payment Schedule</td>
</tr>
<tr>
<td><strong>Section 2: Referral and Authorization Requirements</strong></td>
</tr>
<tr>
<td>Referral Requirements</td>
</tr>
<tr>
<td>• Service Requiring a Referral</td>
</tr>
<tr>
<td>• Services Not Requiring a Referral (Member Self-Referral)</td>
</tr>
<tr>
<td>Referral Process</td>
</tr>
<tr>
<td>Approval of Additional Procedures</td>
</tr>
<tr>
<td>• Additional Procedures Performed in the Specialist Office or Outpatient Hospital/Facility Setting</td>
</tr>
<tr>
<td>• Additional Procedures Requiring Inpatient or SPU Admission</td>
</tr>
<tr>
<td>• Follow-Up Specialty Office Visits</td>
</tr>
<tr>
<td>Out-of-Plan Referrals</td>
</tr>
<tr>
<td>Standing Referrals</td>
</tr>
<tr>
<td>Referrals/Second Opinions</td>
</tr>
<tr>
<td>Prior Authorization Requirements</td>
</tr>
<tr>
<td>• Services that Require Prior Authorization</td>
</tr>
<tr>
<td>Policies and Procedures</td>
</tr>
<tr>
<td>Medically Necessary</td>
</tr>
<tr>
<td>Alerts</td>
</tr>
<tr>
<td>• Benefit Limits and Co-Payments</td>
</tr>
<tr>
<td>• Authorization and Eligibility</td>
</tr>
<tr>
<td>• Department of Health and Human Services Medical Assistance Program Services</td>
</tr>
<tr>
<td>Ambulance</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Dental Services</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>• Covered Services</td>
</tr>
<tr>
<td>Elective Admissions and Elective Short Procedures</td>
</tr>
<tr>
<td>Emergency Admissions, Surgical Procedures and Observation Stays</td>
</tr>
<tr>
<td>• ER Medical Care</td>
</tr>
<tr>
<td>• Emergency Medical Services</td>
</tr>
<tr>
<td>• Emergency SPU Services</td>
</tr>
<tr>
<td>• Emergent Observation Stay Services</td>
</tr>
<tr>
<td>• Emergency Inpatient Admissions</td>
</tr>
<tr>
<td>Emergency Services Provided by Non-Participating Providers</td>
</tr>
<tr>
<td>Family Planning</td>
</tr>
<tr>
<td>• Sterilization</td>
</tr>
<tr>
<td>Home Health Care</td>
</tr>
<tr>
<td>Hospice Care</td>
</tr>
<tr>
<td>Hospital Transfer Policy</td>
</tr>
<tr>
<td>Medical Supplies</td>
</tr>
<tr>
<td>Newborn Care</td>
</tr>
<tr>
<td>Nursing Facility</td>
</tr>
<tr>
<td>• Covered Services</td>
</tr>
<tr>
<td>Obstetrical/Gynecological Services</td>
</tr>
<tr>
<td>• Direct Access</td>
</tr>
<tr>
<td>• Bright Start® Maternity Program Overview</td>
</tr>
<tr>
<td>• Obstetrician’s Role in the Bright Start Maternity Program®</td>
</tr>
<tr>
<td>Ophthalmology Services</td>
</tr>
<tr>
<td>• Non-Routine Eye Care Services</td>
</tr>
<tr>
<td>Outpatient Laboratory Services</td>
</tr>
<tr>
<td>Outpatient Renal Dialysis</td>
</tr>
<tr>
<td>• Free-Standing Facilities</td>
</tr>
<tr>
<td>• Hospital-Based Outpatient Dialysis</td>
</tr>
<tr>
<td>Outpatient Testing</td>
</tr>
<tr>
<td>Outpatient Therapies</td>
</tr>
<tr>
<td>Topic</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical, Occupational and Speech</td>
</tr>
<tr>
<td>Pediatric Preventive Health Care Program</td>
</tr>
<tr>
<td>EPSDT Screens</td>
</tr>
<tr>
<td>EPSDT Covered Services</td>
</tr>
<tr>
<td>EPSDT Expanded Services</td>
</tr>
<tr>
<td>Eligibility for EPSDT Expanded Services</td>
</tr>
<tr>
<td>EPSDT Expanded Services Requiring Prior Authorization</td>
</tr>
<tr>
<td>Obtaining PCP Approval for EPSDT</td>
</tr>
<tr>
<td>EPSDT Expanded Services Approval Process</td>
</tr>
<tr>
<td>EPSDT Expanded Services Denial Process</td>
</tr>
<tr>
<td>EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions</td>
</tr>
<tr>
<td>Age Appropriate Evaluation and Management Codes</td>
</tr>
<tr>
<td>Completing the CMS 1500 or UB-04 Claim Form</td>
</tr>
<tr>
<td>Additional EPSDT Information</td>
</tr>
<tr>
<td>Pharmacy Services</td>
</tr>
<tr>
<td>Drug Formulary</td>
</tr>
<tr>
<td>Pharmacy Prior Authorization Process</td>
</tr>
<tr>
<td>Drugs Requiring Prior Authorization</td>
</tr>
<tr>
<td>Injectable and Specialty Medications</td>
</tr>
<tr>
<td>Bleeding Disorders Management Program Description</td>
</tr>
<tr>
<td>Erythropoiesis-Stimulating Agents (ESA) Policy</td>
</tr>
<tr>
<td>Generic Medications</td>
</tr>
<tr>
<td>Over-the-Counter Medication</td>
</tr>
<tr>
<td>Vitamin Coverage</td>
</tr>
<tr>
<td>Blood Glucose Monitors</td>
</tr>
<tr>
<td>Medication Covered by Other Insurance</td>
</tr>
<tr>
<td>Non-Covered Medications</td>
</tr>
<tr>
<td>Information Available on the Web</td>
</tr>
<tr>
<td>Podiatry Services</td>
</tr>
<tr>
<td>Podiatry Services/Orthotics</td>
</tr>
<tr>
<td>Preventable Serious Adverse Events Payment Policy</td>
</tr>
<tr>
<td>Recipient Restriction Program</td>
</tr>
<tr>
<td>Section 3: Member Eligibility</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Enrollment Process</td>
</tr>
<tr>
<td>• Plan Identification Card</td>
</tr>
<tr>
<td>• Welcome Packet</td>
</tr>
<tr>
<td>Continuing Care</td>
</tr>
<tr>
<td>Verifying Eligibility</td>
</tr>
<tr>
<td>Monthly Panel List</td>
</tr>
<tr>
<td>Change in Recipient Coverage During and Inpatient Stay/Nursing Facility</td>
</tr>
<tr>
<td>Nursing Facilities</td>
</tr>
<tr>
<td>Retroactive Eligibility</td>
</tr>
<tr>
<td>Eligibility for Institutionalized Members</td>
</tr>
<tr>
<td>Incarcerated Member Eligibility</td>
</tr>
<tr>
<td>Pennsylvania ACCESS Card</td>
</tr>
<tr>
<td>Treating Fee-for-Service MA Recipients</td>
</tr>
<tr>
<td>Loss of Benefits</td>
</tr>
<tr>
<td>Section 4: Provider Services</td>
</tr>
<tr>
<td>EDI Technical Support Line</td>
</tr>
<tr>
<td>Provider Claims Service Unit</td>
</tr>
<tr>
<td>Provider Network Management/Provider Contracting</td>
</tr>
<tr>
<td>Provider Services Department</td>
</tr>
<tr>
<td>Member Services</td>
</tr>
<tr>
<td>Section 5: Primary Care Practitioner (PCP) &amp; Specialist Office Standards &amp; Requirements</td>
</tr>
<tr>
<td>PCP Role and Requirements</td>
</tr>
<tr>
<td>Completing Medical Forms</td>
</tr>
<tr>
<td>Vaccines for Children Program</td>
</tr>
<tr>
<td>PCP Reimbursement</td>
</tr>
<tr>
<td>• PCP Fee-for-Service Reimbursement</td>
</tr>
<tr>
<td>• Capitation/Above-Capitation Reimbursement</td>
</tr>
<tr>
<td>Capitation Reimbursement Payment Method</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Procedures Compensated Under Capitation</td>
</tr>
<tr>
<td>Procedures Reimbursed Above Capitation</td>
</tr>
<tr>
<td>The PCP Office Visit</td>
</tr>
<tr>
<td>Forms/Materials Available</td>
</tr>
<tr>
<td>Access Standards for PCPs</td>
</tr>
<tr>
<td>- Appointment Accessibility Standards</td>
</tr>
<tr>
<td>- Additional Requirements of PCPs</td>
</tr>
<tr>
<td>PCP Selection</td>
</tr>
<tr>
<td>Encounter Reporting</td>
</tr>
<tr>
<td>- Completion of Encounter Data</td>
</tr>
<tr>
<td>Transfer of Non-Compliant Members</td>
</tr>
<tr>
<td>Requesting a Freeze or Limitation of Your Member Panel</td>
</tr>
<tr>
<td>Policy Regarding PCP to Member Ratio</td>
</tr>
<tr>
<td>Letter of Medical Necessity (LOMN)</td>
</tr>
<tr>
<td>PCP Responsibilities Under the Patient Self-Determination Act</td>
</tr>
<tr>
<td>Preventive Health Guidelines</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
</tr>
<tr>
<td>- The Specialist Office Visit</td>
</tr>
<tr>
<td>- Reimbursement/Fee-for-Service Payment</td>
</tr>
<tr>
<td>- Specialist Services</td>
</tr>
<tr>
<td>- Specialist Access and Appointment Standards</td>
</tr>
<tr>
<td>- Confidentiality of Medical Records</td>
</tr>
<tr>
<td>- Letters of Medical Necessity (LOMN)</td>
</tr>
<tr>
<td>- Specialist Responsibilities Under the Patient Self-Determination Act</td>
</tr>
<tr>
<td>- Specialist as PCP for Special Needs Members</td>
</tr>
<tr>
<td>PCP and Specialist Office Standards</td>
</tr>
<tr>
<td>- Physical Environment</td>
</tr>
<tr>
<td>- Medical Record Standards</td>
</tr>
<tr>
<td>- Medical Record Retention Responsibilities</td>
</tr>
<tr>
<td><strong>Section 6: Claims and Claim Disputes</strong></td>
</tr>
<tr>
<td>Claims Filing Instructions</td>
</tr>
<tr>
<td>National Provider Identification Number</td>
</tr>
<tr>
<td>Claims Filing Deadlines</td>
</tr>
<tr>
<td>- Original Claims</td>
</tr>
</tbody>
</table>
- Re-submission of Rejected Claims 130
- Re-submission of Denied Claims 130
- Submission of Claims Involving Third Party Liability 130
- Failure to Comply with Claims Filing Deadlines 131

Third Party Liability and Coordination of Benefits 131

Reimbursement for Members with Third Party Resources 131
- Medicare as a Third Party Resource 131
- Commercial Third Party Resources 132
- Capitated Primary Care Practitioners (PCPs) 132

Program Integrity 132

Refunds for Claims Overpayments or Errors 134
Definitions of Fraud, Waste and Abuse 135
- Reporting Fraud, Waste and Abuse 139

Claims Disputes and Appeals 140
- Common Reasons for Claims Rejections and Denials 140
- Rejected Claims 140
- Claims Denied for Missing Information 141
- Adjusted Claims 141
- Emergency Department Payment Level Reconsideration for Participating Providers 141
- Payment Limitations 142
- Claims Disputes 142

**Section 7: Provider Dispute/Appeal Procedures; Member Complaints, Grievances and Fair Hearings** 144

Provider Dispute/Appeals Procedures 145
- Informal Provider Dispute Process 145
- What is a Dispute? 145

Formal Provider Appeals Process 146
- What is an Appeal? 146

First Level Appeal Review 147
- Filing a Request for a First Level Appeal Review 147
- Physician Review of a First Level Appeal 148
- Time Frame for Resolution of a First Level Appeal 148

Second Level Appeal Review 148
- Filing a Request for a Second Level Appeal Review 148
- Appeals Panel Review of a Second Level Appeal 149
- Time Frame for Resolution of a Second Level Appeal 150
# Member Complaints, Grievances and Fair Hearings

- First Level Complaints
- Second Level Complaints
- External Complaint Process
- Expedited Complaints
- Grievances/Grievance Process
- External Grievances
- Expedited Grievances
- DHS Fair Hearing
- Expedited Fair Hearing Process
- Provision of and Payment for Service of Item Following the Decision
- General Procedures for Complaint and Grievances
- Relationship of Provider Formal Appeals Process to Provider Initiated Member Grievances
- Requirements for Grievances filed by Providers on Behalf of Members
- Escrow Requirements for External Grievances (including Expedited Grievances)

## Section 8: Quality Assessment Performance Improvement, Credentialing, and Utilization Management

<table>
<thead>
<tr>
<th>Quality Assessment and Performance Improvement</th>
<th>166</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Assessment and Performance Improvement Program Authority and Structure</td>
<td>167</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Credentialing/Re-Credentialing Requirements</th>
<th>168</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Requirements</td>
<td>168</td>
</tr>
<tr>
<td>Provider Application</td>
<td>170</td>
</tr>
<tr>
<td>Facility Requirements</td>
<td>171</td>
</tr>
<tr>
<td>Facility Application</td>
<td>172</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Access to Physician Information</th>
<th>174</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Sanctioning Policy</td>
<td>174</td>
</tr>
<tr>
<td>Informal Resolution of Quality of Care Concerns</td>
<td>175</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formal Sanctioning Process</th>
<th>176</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Proposed Action to Sanction</td>
<td>176</td>
</tr>
<tr>
<td>Notice of Hearing</td>
<td>176</td>
</tr>
<tr>
<td>Conduct of the Hearing and Notice</td>
<td>176</td>
</tr>
<tr>
<td>Provider’s Rights at the Hearing</td>
<td>177</td>
</tr>
<tr>
<td>Appeal of the Decision of the Peer Review Committee</td>
<td>177</td>
</tr>
<tr>
<td>Summary Actions Permitted</td>
<td>177</td>
</tr>
<tr>
<td>External Reporting</td>
<td>177</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Management Program</th>
<th>177</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Review</td>
<td>178</td>
</tr>
<tr>
<td>Mission and Values</td>
<td>178</td>
</tr>
<tr>
<td>Criteria Availability</td>
<td>178</td>
</tr>
<tr>
<td>Timeliness of UM Decisions</td>
<td>180</td>
</tr>
<tr>
<td>Denial and Appeal Process</td>
<td>181</td>
</tr>
<tr>
<td>Physician Reviewer Availability to Discuss Decision</td>
<td>181</td>
</tr>
<tr>
<td>Denial Reasons</td>
<td>181</td>
</tr>
<tr>
<td>Appeal Process</td>
<td>181</td>
</tr>
</tbody>
</table>
Evaluation of New Technology
Evaluation of Member and Provider Satisfaction and Program Effectiveness

Section 9: Special Needs and Case Management
Postpartum Home Visit Program
Purpose
Home Nursing Visit
Requesting a Postpartum Home Visit

Pediatric Preventive Health Care Program-Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Outreach and Health Education Programs
Tobacco Cessation
Breast Cancer Screening and Outreach Program (BCSOP)
Domestic Violence Intervention
The Provider’s Role

Pennsylvania’s Early Intervention System
Specialists as PCPs for Special Needs Members

Section 10: Member Rights and Responsibilities
Member Rights and Responsibilities
Member Rights
Member Responsibilities
Patient Self-Determination Act
Living Will
Durable Health Care Power of Attorney

Section 11: Regulatory Provisions
Access to and Financial Responsibility of Services
Member’s Financial Responsibilities
Services Provided by a Non-Participating Provider
Services Provided Without Required Referral/Authorization
Service Not Covered
Member Accessibility to Providers for Emergency Care

Compliance with the HIPAA Privacy Regulations
Allowed Activities Under the HIPAA Privacy Regulations
Contact Information
Cultural Competency
Corporate Confidentiality Policy
Procedure
Provider Protections

Medical Assistance Regulations

Section 13: APPENDIX
About AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast

Who We Are


**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.
## Important Contact Numbers

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>AmeriHealth Caritas Northeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud and Abuse Hotline</td>
<td>Phone: 866-833-9718</td>
<td>Phone: 866-833-9718</td>
</tr>
<tr>
<td>Main Office</td>
<td>Phone: 1-877-693-8271 Fax: 1-717-651-1673</td>
<td>Phone: 1-877-693-8271 Fax: 1-717-651-1673</td>
</tr>
<tr>
<td>ACS Enrollment</td>
<td>Phone: 1-800-440-3989</td>
<td>Phone: 1-800-440-3989</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>See Table Below</td>
<td>See Table Below</td>
</tr>
<tr>
<td>Bright Start Maternity Program</td>
<td>Phone: 1-877-364-6797 Fax: 1-866-755-9935</td>
<td>Phone: 1-888-208-9528 Fax: 1-855-809-9205</td>
</tr>
<tr>
<td>Care/Disease Management</td>
<td>Phone: 1-877-693-8271, option 2 Fax: 1-866-755-0030</td>
<td>Phone: 1-888-208-5966 Fax: 1-888-208-9532</td>
</tr>
<tr>
<td>Clinical Sentinel Hotline/Department of Human Services</td>
<td>Phone: 1-800-426-2090</td>
<td>Phone: 1-800-426-2090</td>
</tr>
<tr>
<td>CONNECT Hotline (PA Early Intervention)</td>
<td>Phone: 1-800-692-7288</td>
<td>Phone: 1-800-692-7288</td>
</tr>
<tr>
<td>Contracting</td>
<td>Phone: 1-866-546-7972 Fax: 1-717-651-1673</td>
<td>Phone: 1-866-546-7972 Fax: 1-717-651-1673</td>
</tr>
<tr>
<td>Credentialing</td>
<td>Phone: 1-800-642-3510, option 2</td>
<td>Phone: 1-855-809-9204</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Phone: 1-855-434-9241</td>
<td>Phone: 1-855-434-9241</td>
</tr>
<tr>
<td>Discharge Planning/Home Care/Infusion/Hospice/SNF</td>
<td>Phone: 1-877-693-8272 Fax: 1-866-755-9982</td>
<td>Phone: 1-888-498-0504 Fax: 1-888-740-8137</td>
</tr>
<tr>
<td>DME Prior Authorization Services</td>
<td>Phone: 1-800-521-6622 Fax: 1-866-755-9841</td>
<td>Phone: 1-888-498-0504 Fax: 1-888-208-2346</td>
</tr>
<tr>
<td>EDI Technical Support</td>
<td>Phone: 1-877-234-4271</td>
<td>Phone: 1-855-859-4103</td>
</tr>
<tr>
<td>Change Health Care/Emdeon Provider Support Line</td>
<td>Phone: 1-800-845-6592</td>
<td>Phone: 1-800-845-6592</td>
</tr>
<tr>
<td>Electronic Billing Questions</td>
<td>Phone: 1-877-234-4272</td>
<td>Phone: 1-855-859-4103</td>
</tr>
<tr>
<td>EPSDT Unit (Pediatric Preventive Health Care)</td>
<td>Phone: 1-855-300-8334 Fax: 1-866-208-8145</td>
<td>Phone: 1-855-300-8334 Fax: 1-866-208-8145</td>
</tr>
</tbody>
</table>

**Plan Name**

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania (ACP)</th>
<th>1-800-521-6007</th>
<th><a href="http://www.amerihealthcaritaspa.com">www.amerihealthcaritaspa.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast (ACN)</td>
<td>1-888-208-7370</td>
<td><a href="http://www.amerihealthcaritasnortheast.com">www.amerihealthcaritasnortheast.com</a></td>
</tr>
<tr>
<td>Program</td>
<td>Phone: 1-800-521-6007</td>
<td>Fax: 1-866-755-0030</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Integrated Care Management</td>
<td>Phone: 1-877-693-8271, option 2</td>
<td>Fax: 1-866-755-0030</td>
</tr>
<tr>
<td>Medical Assistance Transportation Program (MATP)</td>
<td><a href="http://matp.pa.gov/CountyContact.aspx">http://matp.pa.gov/CountyContact.aspx</a></td>
<td><a href="http://matp.pa.gov/CountyContact.aspx">http://matp.pa.gov/CountyContact.aspx</a></td>
</tr>
<tr>
<td>Member Services</td>
<td>Phone: 1-888-991-7200</td>
<td>Phone: 1-855-809-9200</td>
</tr>
<tr>
<td>Phone: 1-888-482-8057</td>
<td>Phone: 1-888-482-8057</td>
<td></td>
</tr>
<tr>
<td>OB Deliveries/Admission Notification Forms</td>
<td>Phone: 1-800-521-6622</td>
<td>Fax: 1-855-332-0991</td>
</tr>
<tr>
<td>Phone: 1-888-482-8057</td>
<td>Phone: 1-888-482-8057</td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-424-5657</td>
<td>Phone: 1-800-588-8142</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy, including Chiropractic</td>
<td>1-800-521-6622, option 8</td>
<td>1-888-498-0504, option 8</td>
</tr>
<tr>
<td>Outreach and Health Education Programs</td>
<td>1-877-693-8271, option 2</td>
<td>1-888-208-5966</td>
</tr>
<tr>
<td>Peer-to-Peer Hotline</td>
<td>Phone: 1-800-521-6622</td>
<td>Phone: 1-800-521-6622</td>
</tr>
<tr>
<td>Pennsylvania Eligibility Verification System (EVS)</td>
<td>Phone: 1-800-766-5387</td>
<td>Phone: 1-800-766-5387</td>
</tr>
<tr>
<td>Pennsylvania Tobacco Cessation Information</td>
<td>Phone: 1-800-784-8669</td>
<td>Phone: 1-800-784-8669</td>
</tr>
<tr>
<td>Pharmacy Services/Pharmacy Prior Authorizations</td>
<td>Phone: 1-866-610-2774</td>
<td>Fax: 1-888-981-5202</td>
</tr>
<tr>
<td>Pharmacy Opioid Prior Authorization</td>
<td>Phone: 1-800-578-0898</td>
<td>Fax: 1-877-708-9080</td>
</tr>
<tr>
<td>Prior Authorization Services</td>
<td>Phone: 1-800-521-6622</td>
<td>Fax: 1-866-755-9949</td>
</tr>
<tr>
<td>Provider Claims Services Unit</td>
<td>Phone: 1-800-521-6007</td>
<td>Phone: 1-888-208-7370</td>
</tr>
<tr>
<td>Provider Services</td>
<td>Phone: 1-800-521-6007</td>
<td>Phone: 1-888-208-7370</td>
</tr>
<tr>
<td>Quest Diagnostics (Lab)</td>
<td>Phone: 1-800-825-7380</td>
<td><a href="http://www.questdiagnostics.com">www.questdiagnostics.com</a></td>
</tr>
<tr>
<td>Rapid Response and Outreach</td>
<td>Phone: 1-800-684-5503</td>
<td>Phone: 1-855-859-4110</td>
</tr>
<tr>
<td>Retention Unit</td>
<td>Phone: 1-855-737-7648</td>
<td>Phone: 1-855-737-7648</td>
</tr>
<tr>
<td>Special Needs Unit</td>
<td>Phone: 1-800-684-5503</td>
<td>Phone: 1-888-498-0766</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supply Request Form</th>
<th>Fax: 1-215-937-8800</th>
<th>Fax: 1-215-937-8800</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTY-Telecommunications for the Hearing Impaired</td>
<td>Phone: 1-800-684-5505</td>
<td>Phone: 1-855-859-4109</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Phone: 1-800-521-6622</td>
<td>Phone: 1-888-498-0504</td>
</tr>
<tr>
<td>24-Hour Nurse Hotline</td>
<td>Phone: 1-866-566-1513</td>
<td>Phone: 1-866-566-1513</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH AND SUBSTANCE ABUSE-By County

<table>
<thead>
<tr>
<th>County</th>
<th>Behavioral Health Plan</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Community Care Behavioral Health</td>
<td>1-866-738-9849</td>
</tr>
<tr>
<td>Allegheny</td>
<td>Community Care Behavioral Health</td>
<td>1-800-553-7499</td>
</tr>
<tr>
<td>Armstrong</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5969</td>
</tr>
<tr>
<td>Beaver</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5970</td>
</tr>
<tr>
<td>Bedford</td>
<td>PerformCare</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Berks</td>
<td>Community Care Behavioral Health</td>
<td>1-855-520-9715</td>
</tr>
<tr>
<td>Blair</td>
<td>Community Care Behavioral Health</td>
<td>1-866-773-7892</td>
</tr>
<tr>
<td>Bradford</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Butler</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5971</td>
</tr>
<tr>
<td>Cambria</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-866-404-4562</td>
</tr>
<tr>
<td>Cameron</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Carbon</td>
<td>Community Care Behavioral Health</td>
<td>1-866-473-5862</td>
</tr>
<tr>
<td>Centre</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Clarion</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Clearfield</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Clinton</td>
<td>Community Care Behavioral Health</td>
<td>1-855-520-9787</td>
</tr>
<tr>
<td>Columbia</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Crawford</td>
<td>Value Behavioral Health of PA</td>
<td>1-866-404-4561</td>
</tr>
<tr>
<td>County</td>
<td>Health Provider</td>
<td>Phone Number</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Cumberland</td>
<td>PerformCare</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Dauphin</td>
<td>PerformCare</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Erie</td>
<td>Community Care Behavioral Health</td>
<td>1-855-224-1777</td>
</tr>
<tr>
<td>Fayette</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5972</td>
</tr>
<tr>
<td>Forest</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Franklin</td>
<td>PerformCare</td>
<td>1-866-773-7917</td>
</tr>
<tr>
<td>Fulton</td>
<td>PerformCare</td>
<td>1-866-773-7917</td>
</tr>
<tr>
<td>Greene</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5973</td>
</tr>
<tr>
<td>Huntingdon</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Indiana</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5974</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Juniata</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Lackawanna</td>
<td>Community Care Behavioral Health</td>
<td>1-866-668-4696</td>
</tr>
<tr>
<td>Lancaster</td>
<td>PerformCare</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Lawrence</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5975</td>
</tr>
<tr>
<td>Lebanon</td>
<td>PerformCare</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Lehigh</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-866-238-2311</td>
</tr>
<tr>
<td>Luzerne</td>
<td>Community Care Behavioral Health</td>
<td>1-866-668-4696</td>
</tr>
<tr>
<td>Lycoming</td>
<td>Community Care Behavioral Health</td>
<td>1-855-520-9787</td>
</tr>
<tr>
<td>McKean</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Mercer</td>
<td>Value Behavioral Health of PA</td>
<td>1-866-404-4561</td>
</tr>
<tr>
<td>Mifflin</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Monroe</td>
<td>Community Care Behavioral Health</td>
<td>1-866-473-5862</td>
</tr>
<tr>
<td>Montour</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
</tbody>
</table>

**BEHAVIORAL HEALTH AND SUBSTANCE ABUSE-By County**
<table>
<thead>
<tr>
<th>County</th>
<th>Provider Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northampton</td>
<td>Magellan Behavioral Health of PA</td>
<td>1-866-238-2312</td>
</tr>
<tr>
<td>Northumberland</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Perry</td>
<td>PerformCare</td>
<td>1-888-722-8646</td>
</tr>
<tr>
<td>Pike</td>
<td>Community Care Behavioral Health</td>
<td>1-866-473-5862</td>
</tr>
<tr>
<td>Potter</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Schuylkill</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Snyder</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Somerset</td>
<td>PerformCare</td>
<td>1-866-773-7891</td>
</tr>
<tr>
<td>Sullivan</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Susquehanna</td>
<td>Community Care Behavioral Health</td>
<td>1-866-668-4696</td>
</tr>
<tr>
<td>Tioga</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Union</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Venango</td>
<td>Value Behavioral Health of PA</td>
<td>1-866-404-4561</td>
</tr>
<tr>
<td>Warren</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Washington</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5976</td>
</tr>
<tr>
<td>Wayne</td>
<td>Community Care Behavioral Health</td>
<td>1-866-878-6046</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>Value Behavioral Health of PA</td>
<td>1-877-688-5977</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Community Care Behavioral Health</td>
<td>1-866-668-4696</td>
</tr>
<tr>
<td>York</td>
<td>Community Care Behavioral Health</td>
<td>1-866-542-0299</td>
</tr>
<tr>
<td>IMPORTANT DEFINITIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Abuse</strong></td>
<td>Includes provider reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health program.</td>
<td></td>
</tr>
<tr>
<td><strong>ACCESS Card</strong></td>
<td>An identification card issued by 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Managed Care Organization (BH-MCO)</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Case Management Services</strong></td>
<td>Services which will assist individuals in gaining access to necessary medical, social, educational and other services.</td>
<td></td>
</tr>
<tr>
<td><strong>Centers for Medicare and Medicaid Services (CMS)</strong></td>
<td>The federal agency within the Department of Human Services responsible for oversight of MA Programs.</td>
<td></td>
</tr>
<tr>
<td><strong>Certified Nurse Midwife</strong></td>
<td>An individual licensed under the laws within the scope of Chapter 6 of Professions &amp; Occupations, 63 P.S. 171-176.</td>
<td></td>
</tr>
<tr>
<td><strong>Certified Registered Nurse Practitioner (CRNP)</strong></td>
<td>A registered 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Claim</strong></td>
<td>A bill from a provider of a medical service or product that is assigned a claim reference number.</td>
<td></td>
</tr>
<tr>
<td><strong>A Claim</strong></td>
<td>A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.</td>
<td></td>
</tr>
<tr>
<td><strong>Clean Claim</strong></td>
<td>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 MCO’s Claims system. Claims under investigation for Fraud or abuse or under review to determine if they are Medically Necessary are not Clean Claims.</td>
<td></td>
</tr>
<tr>
<td><strong>Client Information System (CIS)</strong></td>
<td>DHS's database of Members. The database contains demographic and eligibility information for all Members.</td>
<td></td>
</tr>
<tr>
<td><strong>Complaint</strong></td>
<td>A dispute or objection regarding a Network Provider or the coverage, operations, or management policies of a Physical Health Managed Care Organization (PH-MCO), which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department. A Complaint may arise from circumstances including but not limited to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- a denial because the requested service/item is not a covered benefit; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- a failure of the PH-MCO to meet the required time frames for providing a service/item; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- a failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- a denial of payment by the PH-MCO after a service has been delivered because the service/item was provided, without authorization by the PH-MCO, by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- a denial of payment by the PH-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Member.</td>
<td></td>
</tr>
<tr>
<td><strong>The term does not include a Grievance.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Concurrent Review** | A review conducted by the Plan during a course of treatment to determine whether the amount,
duration and scope of the prescribed services continue to be Medically Necessary or whether a different service or lesser level of service is Medically Necessary.

**County Assistance Office (CAO)**

The county offices of DHS 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 Competency**

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

**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 services, but for a lesser amount, scope or duration than requested; or disapproves provision of the requested services, 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 Services.

**Denied Claim**

An Adjudicated Claim that does not result in a payment to a Provider.

**Department**

The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

**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:
  - Self-care
  - Receptive and expressive language
  - Learning
<p>| <strong>Disease Management</strong> | 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. |
| <strong>Dispute</strong> | A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity. |
| <strong>Dual Eligibles</strong> | 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. |
| <strong>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</strong> | 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). |
| <strong>Early Intervention System</strong> | 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 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. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Eligibility Period</td>
<td>A period of time during which a Member is eligible to receive benefits. An Eligibility Period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date signifies an open-ended Eligibility Period.</td>
</tr>
<tr>
<td>Eligibility Verification System (EVS)</td>
<td>An automated system available to Providers and other specified organizations for automated verification of Members’ current and past (up to three hundred sixty-five [365] days) MA eligibility, PH-MCO enrollment, PCP assignment, Third Party Resources, and scope of benefits.</td>
</tr>
</tbody>
</table>
| 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  
Covered inpatient and outpatients services that:  
- Are furnished by a Health Care 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. |
<p>| Encounter | Any 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 person eligible to receive services under the MA Program in the Commonwealth of Pennsylvania and who is mandated to be enrolled in the HealthChoices Program. |</p>
<table>
<thead>
<tr>
<th><strong>Enrollment</strong></th>
<th>The process by which a Member’s coverage is initiated.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expanded Services</strong></td>
<td>Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C.A. 1396 et seq, but not included in the State’s Medicaid Plan, which is provided to Members.</td>
</tr>
<tr>
<td><strong>Experimental Treatment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td>Services that enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.</td>
</tr>
<tr>
<td><strong>Federally Qualified Health Center (FQHC)</strong></td>
<td>An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d (l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.</td>
</tr>
<tr>
<td><strong>Formal Provider Appeals</strong></td>
<td>A Formal Provider 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. Types of issues addressed through the Formal Provider Appeals Process are:</td>
</tr>
<tr>
<td></td>
<td>• Denials based on medical necessity for services already rendered by the Health Care Provider to a Member, including denials that:</td>
</tr>
<tr>
<td></td>
<td>o 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</td>
</tr>
<tr>
<td></td>
<td>o Do not contain a Member consent that conforms with applicable law for a Member Complaint or Grievance filed by a Health Care Provider on behalf of a Member</td>
</tr>
<tr>
<td></td>
<td>• Disputes not resolved to the Network Provider’s satisfaction through the Plan’s Informal Provider Dispute Process</td>
</tr>
<tr>
<td></td>
<td>Formal Provider Appeals do not include: (a) Claims</td>
</tr>
</tbody>
</table>
denied because they were not filed within the 180-day filing time limit; (b) denials issued through the Prior Authorization process; (c) credentialing denials for any reason; and (d) Network Provider terminations based on quality of care or other for cause reasons.

<table>
<thead>
<tr>
<th><strong>Formulary</strong></th>
<th>A Department approved list of outpatient drugs determined the PH-MCO's P&amp;T Committee to have a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the Members.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fraud</strong></td>
<td>Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including a contractor, a subcontractor, a Health Care Provider, a State employee, or a Member, among others.</td>
</tr>
<tr>
<td><strong>Grievance</strong></td>
<td>Requests to have the Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A Grievance may be filed regarding the Plan's decision to: 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level or service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item, but approve an alternative service/item. The term does not include a complaint.</td>
</tr>
<tr>
<td><strong>Health Care Provider</strong></td>
<td>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 nurse practitioner, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.</td>
</tr>
</tbody>
</table>

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 coverage for individuals who make certain job changes, retire, become disabled, or die.
<table>
<thead>
<tr>
<th>Health Maintenance Organization (HMO)</th>
<th>A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthChoices Program</td>
<td>The name of Pennsylvania’s 1915(b) waiver program to provide mandatory managed health care to MA recipients.</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>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.</td>
</tr>
<tr>
<td>Intermediate Care Facility for the Intellectually Disabled and Other Related Conditions (ICF/MR/ORC)</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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 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. |
of physical or behavioral health services under the HealthChoices Program.

<table>
<thead>
<tr>
<th>Medical Assistance (MA)</th>
<th>The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C.A 1396 et seq., and regulations promulgated there under, and 62 P.S. 101 et seq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Assistance Transportation Program (MATP)</td>
<td>A non-emergency medical transportation service that provides MA compensable transportation to and from a medical facility, physician’s office, dentist’s office, hospital, clinic, pharmacy, or purveyor of medical equipment for the purpose of receiving medical treatment or medical evaluation or purchasing prescription drugs or medical equipment.</td>
</tr>
</tbody>
</table>
| Medically Necessary | A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:  
• The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability  
• The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability  
• The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age  

Determinations 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. |
| 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 |
| **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 with the Plan who are providing covered services to Members. |
| **Network Provider** | A Provider who has a written Provider Agreement with and is credentialed by the Plan, and who participates in the Plan's Provider Network to serve 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 |
| **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.

<table>
<thead>
<tr>
<th><strong>Out-of-Plan Services</strong></th>
<th>Services that are non-plan, non-capitated and are not the responsibility of the Plan under the HealthChoices Program comprehensive benefit package.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health Managed Care Organization (PH-MCO)</strong></td>
<td>A risk-bearing entity which has an agreement with DHS to manage the purchase and provision of Physical Health Services under the HealthChoices Program.</td>
</tr>
<tr>
<td><strong>Post-Stabilization Services</strong></td>
<td>Medically Necessary non-Emergency Services furnished to a Member after the Member is stabilized following an Emergency Medical Condition.</td>
</tr>
<tr>
<td><strong>Primary Care Case Management (PCCM)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Primary Care Practitioner (PCP)</strong></td>
<td>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 Member.</td>
</tr>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>PROMISe™ Provider Identification Number (PPID Number)</strong></td>
<td>A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>A person, firm or corporation, enrolled in the Pennsylvania MA Program, which provides services</td>
</tr>
<tr>
<td><strong>Term</strong></td>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provider Agreement</td>
<td>Any Department approved written agreement between the Plan and a Provider to provide medical or professional services to the Plan Members.</td>
</tr>
<tr>
<td>Quality Assessment and Performance Improvement</td>
<td>An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>A review conducted by the Plan to determine whether services were delivered as prescribed and consistent with the Plan's payment policies and procedures.</td>
</tr>
<tr>
<td>Sanction</td>
<td>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.</td>
</tr>
<tr>
<td>Short Procedure Unit (SPU)</td>
<td>A facility that can be a hospital or free standing unit that performs diagnostic or surgical procedures which do not require an overnight stay. A SPU procedure includes up to 23 hours of post procedure assessment and medical follow up care to assure the recovery of the Member for a safe discharge from the facility.</td>
</tr>
<tr>
<td>Special Needs</td>
<td>The circumstances for which a Member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DHS.</td>
</tr>
<tr>
<td>Subcontract</td>
<td>Any 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 the HealthChoices Program.</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>The primary 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.</td>
</tr>
<tr>
<td><strong>Title XVIII (Medicare)</strong></td>
<td>A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C.A. 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.</td>
</tr>
<tr>
<td><strong>Transitional Care Home</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>United States</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Urgent Medical Condition</strong></td>
<td>Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The terms also include situations where a person’s discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.</td>
</tr>
<tr>
<td><strong>Utilization Management</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Vaccine For Children (VFC)</strong></td>
<td>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</td>
</tr>
<tr>
<td>Waste</td>
<td>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.</td>
</tr>
</tbody>
</table>
Section 1: Covered Benefits
Covered Benefits
AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast (hereafter referred to collectively (where possible) 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 or www.amerihealthcaritasnortheast.com → Providers → Billing → Member co-payment 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
- Primary Care Services
- Physical, Occupational and Speech Therapy
- Rehabilitation Services
- Renal Dialysis
- Vision Care****

* Please note! Under the HealthChoices Program, behavioral health services are coordinated through, and provided by, the Member's BH-MCO. These services are not part of the Plan's benefit package, but are available to all Plan Members through the BH-MCO's.
** Some Specialty Dental Services may require a referral.
*** For Members with a life-threatening, degenerative or disabling disease or condition, or Members with other Special 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 or the AmeriHealth Caritas Northeast Provider Services Department at 1-888-208-7370.
**** Some Specialty Eye Care Services may require a referral.

IMPORTANT NOTE:
AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast are 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 and AmeriHealth Caritas Northeast members, must be enrolled in the Pennsylvania Medical
AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast 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 II);
  - 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
- Experimental Treatment and investigational procedures, services and/or drugs
- Home Modifications (for example, chair lifts)
- 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
- Venipuncture (not reimbursable independent of associated service, i.e. office visit).
- Radiopharmaceuticals (not reimbursable independent of associated radiologic service).
- 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

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 or the AmeriHealth Caritas Northeast Provider Services Department at 1-888-208-7370.
Member co-payment schedules may be found on our websites at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com → Providers → Billing → Member co-pay schedule.

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.

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 or http://www.amerihealthcaritasnortheast.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 and AmeriHealth Caritas Northeast 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 and AmeriHealth Caritas Northeast members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the websites at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com →Providers→Communications → DHS and Medical Assistance Bulletins:

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast 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.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider+

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, Drug and Alcohol treatment (a list of Behavioral Health Providers is located in this Section of the Manual)

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

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

*** Some Specialty Dental Services may require a referral. See "Dental Services" in this section of the Manual.

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

**Referral Process**

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

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast are 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 and AmeriHealth Caritas Northeast members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the websites at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com →Providers →Communications → DHS and Medical Assistance Bulletins.

**AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast 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.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider

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
- 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 and www.amerihealthcaritasnortheast.com. (If an appropriate Network Provider is not listed in the Network Provider Directory please call Provider Services at:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Provider Services Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-521-6007</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-7370</td>
</tr>
</tbody>
</table>

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, call the AmeriHealth Caritas Pennsylvania Utilization Management Department 1-800-521-6622 or the AmeriHealth Caritas Northeast Utilization Management Department at 1-888-498-0504 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.

Additional Procedures Requiring Inpatient or SPU Admission

When the Specialist determines that additional medical or surgical procedures require an inpatient or SPU admission, the Specialist must first determine if the procedures require further Prior Authorization. See "Prior Authorization Requirements" in this section of the Manual. When a procedure does require Prior Authorization, the Specialist should contact AmeriHealth Caritas Pennsylvania Utilization Management Department at 1-800-521-6622 or the AmeriHealth Caritas Northeast Utilization Management Department at 1-888-498-0504 to obtain Prior Authorization. The admission will be reviewed for medical necessity and a case reference number will be assigned. Pre-approval for medical/surgical admissions may be requested directly by the attending specialist. It is not necessary that the Primary Care Practitioner (PCP) be contacted first, however, the Plan requires Specialists to maintain contact with the referring PCP regarding the 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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Utilization Management Department Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-521-6622</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-498-0504</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Provider Services Department Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-521-6007</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-7370</td>
</tr>
</tbody>
</table>

Standing Referrals
For Members with a life-threatening, degenerative or disabling disease or condition, or Members with other Special Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Provider Services Department Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-521-6007</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-7370</td>
</tr>
</tbody>
</table>

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

REMEMBER: The most up to date listing of services requiring Prior Authorization can be found in the Provider Center at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com in the Provider Reference Guide or in posted updates.

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.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider

SERVICES THAT REQUIRE PRIOR AUTHORIZATION:

- All elective (scheduled) inpatient hospital admissions medical and surgical including rehabilitation.
- All elective transplant evaluations and procedures.
- Elective/non-emergent air ambulance transportation.
- All elective transfers for inpatient and/or outpatient services between acute care facilities.
- Skilled nursing facility admission 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.
- Gastroenterology services – (codes 91110 and 91111 only).
- Bariatric surgery.
- Prior authorization is required for all pain management services, with the exception of:
  - Services that are on the Pennsylvania Medical Assistance (PA MA) fee schedule and are provided in a participating physician office setting (POS 11).
- 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.
- Home health services performed by a network provider.
  - Prior authorization is not required for up to six 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.
  - 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) monthly rentals:
  - DME monthly rentals of items in excess of $750 per month.

• DME purchases:
  - Purchase of all items in excess of $750.
  - The purchase of all wheelchairs (motorized and manual) and all wheelchair items (components) regardless of cost per item.
  - Enterals:
    - Prior authorization is required for members over age 21.
    - Prior authorization is required when the request is in excess of $500/month for members under age 21.
  - 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 a 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 are 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.
  - 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 National Imaging Associates (NIA) at www.radmd.com or calling:
      - 1-800-424-5657 for AmeriHealth Caritas Pennsylvania members.
      - 1-800-588-8142 for AmeriHealth Caritas Northeast members.

• Cardiac or pulmonary rehabilitation.
• Chiropractic services after the initial visit.
• 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.
• 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 a PPECC/medical daycare.
  o Guidelines:
    ▪ Member is <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.
    ▪ Member Services’ Transportation Department will be notified with each ambulance approval to initiate and/or continue ambulance transport services.

• Select prescription medications. For information on which prescription drugs require authorization, see the Plan’s Formulary at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com →Pharmacy→ 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.

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/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.dpw.state.pa.us/portal/Default.aspx?alias=promise.dpw.state.pa.us/portal/provider

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT FOR THE SERVICE(S) AUTHORIZED. THE PLAN RESERVES THE RIGHT TO ADJUST ANY PAYMENT MADE FOLLOWING A REVIEW OF MEDICAL RECORD AND DETERMINATION OF MEDICAL NECESSITY OF SERVICES PROVIDED.

Any additional questions regarding prior authorization requests may be addressed by calling:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Utilization Management/Prior Authorization Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-521-6622</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-498-0504</td>
</tr>
</tbody>
</table>

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 or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

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.

Alerts

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 Benefits Grid located in Appendix I of this Manual or in the AmeriHealth Caritas Pennsylvania Provider Center at www.amerihealthcaritaspa.com or AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com.

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 CSH. 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 CSH 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 oxygen or other life support treatment en route
- Because of the medical history of the Member and present condition, there is reason to believe that oxygen or 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 drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not Medically Necessary in an inpatient facility

Behavioral Health Services
Behavioral Health Services, including all mental health, drug and alcohol services are provided by county-specific behavioral health plans. Go here for more information:

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 above.

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 drug and alcohol records.
- Refer Members to the appropriate BH-MCO, once a mental health or drug and alcohol problem is suspected or diagnosed
- To the extent permitted by law, participate in the appropriate sharing of necessary clinical information with the Behavioral Health Provider including, if requested, all prescriptions the 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 drug, so that the Member may receive appropriate support and services necessary to effectively treat the problem

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

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)
- EPSDT behavioral health rehabilitation services for Members up to age 21

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 abuse resources, including information about Centers of Excellence and resources for pregnant members with substance abuse disorders, please refer to our websites at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) → Providers → Resources → Behavioral health and substance abuse resources.

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](http://www.amerihealthcaritaspa.com/pharmacy/index.aspx) or [http://www.amerihealthcaritasnortheast.com/pharmacy/index.aspx](http://www.amerihealthcaritasnortheast.com/pharmacy/index.aspx)

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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 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 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200. Providers with inquiries regarding covered dental services should call the Plan’s Dental Provider Services at 1-855-434-9241. Provider Services staff are available Monday-Friday 8:00A.M. – 6:00 P.M.

**All Members have dental benefits.** Contact Dental Provider Services at 1-855-434-9241 for more information.

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

A co-payment may apply per visit to a dental provider for members 18 years of age and older. See page 23 and 24 for the complete list of co-payments.

**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](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast](http://www.amerihealthcaritasnortheast) or by calling AmeriHealth Caritas Pennsylvania Member Services at 1-888-991-7200 or AmeriHealth Caritas Northeast Member Services at 1-855-809-9200.

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

- Anesthesia
- Orthodontics*
- Check-ups
- Periodontal services
- Cleanings
- Fluoride Treatments (topical fluoride varnish can also be done by a PCP or CRNP)**
- Silver Diamine Fluoride
- 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.

** Participating PCPs and CRNPs with appropriate training and certification may administer and bill for fluoride varnish treatments for children less than five (5) years old up to a maximum of four (4) times per year. Fluoride varnish is defined as a service that may be provided by a participating PCP during which each tooth in a small child (less than 5 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.amerihealthcaritspa.com or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com.

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.

**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
- Root Canals* and **
- Dentures**
- Surgical procedures*
- Anesthesia*
- Emergencies
- Periodontal**
- Endodontics**

*Prior 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 provider 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, he/she must get a benefit limit exception to get another partial, full 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 1-855-434-9241 to request a benefit limit exception. Refer to the Dental Provider Supplement Manual for detailed information about the Benefit Limit Exception Process.

The Plan will 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; or
• The Member is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for periodontal services included in the Plan’s benefit program.

For any questions on eligibility or dental benefits, please contact the Dental Provider Service Department at **1-855-434-9241**.

**Durable Medical Equipment**

**Covered Services**
The Plan’s Members are eligible to receive Medically Necessary durable medical equipment (DME) needed for home use.

All DME purchases or monthly rentals that cost more than $750, and all wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or Member age must be Prior Authorized with the following exceptions:

**Enteral Nutritional Supplements:**
• Prior Authorization is required for Members age 21 and over
• Prior Authorization is required when the request is in excess of $500/month for Members under the age of 21 or for certain items that are more than $200/month
• If the Enteral Nutritional Supplements requested is the only source of nutrition for the Member, the request is approved
• All requests for Enteral Nutritional Supplements for Members under the age of 5 must be checked for WIC eligibility
• Requests with a diagnosis of AIDS are processed following the guidelines regarding waiver information found on the DHS website at: http://www.DHS.pa.gov/learnaboutDHS/waiverinformation/
**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).
- 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 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.

**Home Oxygen Therapy**
All requests for oxygen and oxygen equipment require authorization. Initial authorizations are for 6 months. Reauthorization require 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 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504. 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:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>Fax number-1-866-755-9841</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>Fax number-1-888-208-2346</td>
</tr>
</tbody>
</table>

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 AmeriHealth Caritas Northeast DME Unit at 1-888-498-0504.

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 or AmeriHealth Caritas Northeast's Utilization Management Department at 1-888-498-0504 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 or AmeriHealth Caritas Northeast's Utilization Management Department at 1-888-498-0504.
- 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 AmeriHealth Caritas Northeast's Provider Services Department at 1-888-208-7370 or check eligibility online at www.navinet.net.
- SPU procedures, which have been prior authorized for a particular date, may require rescheduling. The SPU authorizations are automatically assigned a fourteen (14) day window (the scheduled procedure date plus thirteen 13 days during which a SPU procedure can be rescheduled without notifying the Plan). Should the rescheduled date cross a calendar month, the Network Provider is responsible for verifying that the 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" in Section VII 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 the Plan of the admission and provide clinical information to establish medical necessity. Utilization Management assigns the most appropriate level of care based upon the clinical information provided, including history of injury or illness, treatment provided in the ER and patient's response to treatment, clinical findings of diagnostic tests, and interventions taken. An appropriate level of care, for an admission from the ER, may be any one of the following:

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

ER Medical Care

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

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

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 (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 Plan's dedicated web page to child abuse prevention on the provider center at:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th><a href="http://www.amerihealthcaritaspa.com">www.amerihealthcaritaspa.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td><a href="http://www.amerihealthcaritasnortheast.com">www.amerihealthcaritasnortheast.com</a></td>
</tr>
</tbody>
</table>

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:

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
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. Should the PCP direct the Member to the ER after telephone or office contact, the ER staff should screen Members immediately upon arrival. 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 for
Authorization or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period. 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 for authorization, or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. 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 usually requiring less than forty-eight (48) hours of care for the monitoring and treatment of patients with medical conditions related to pregnancy, 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:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>AmeriHealth Caritas Northeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-800-521-6622</td>
<td>Phone: 1-888-498-0504</td>
</tr>
<tr>
<td>Fax: 1-855-332-0991</td>
<td>Fax: 1-888-742-2377</td>
</tr>
</tbody>
</table>

or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. A separate telephone call is required to the Utilization Management Department to determine medical necessity. The facility staff should be prepared to provide information to support the need for continued medical care beyond the 24 hours. The information should include stabilization period; treatment received during observation; the response to treatment; result of post treatment diagnostic tests; and the treatment plan.

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 Northeast 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 Northeast’s Patient Care Management Department via a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and 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” in Section VII of the Manual.

Medical Observation Stay
A Medical Observation Stay is defined as a stay requiring less than forty-eight (48) hours of care for the observation of 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 at participating facilities.**

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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 for authorization or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 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 fax #1-855-332-0991 or AmeriHealth Caritas Northeast Admission Notification fax #1-888-742-2377 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 www.amerihealthcaritasnortheast), or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The Observation, SPU or ER charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the Observation, SPU or ER services. The inpatient case reference number should be noted on the bill.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Member Complaints, Grievances and Fair Hearings" in Section VII 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 forty-eight (48) hours 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’s monitoring of the appropriateness of a continued inpatient stay beyond approved days, according to established criteria, under the direction of the Plan’s Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the Plan must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Emergency Services Provided by Non-Participating Providers

The Plan will reimburse Health Care Providers who are not enrolled with the Plan when they provide Emergency Services for 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. This applies to non-participating out-of-state providers as well.

Enroll by visiting: http://provider.enrollment.dpw.state.pa.us/
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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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 or www.amerihealthcaritasnortheast.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 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200.

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 interpreter services, if necessary, or other interpreter 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. The claim and consent forms will be retained by the Plan.

Submit claims to:
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast 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 Health Care Management Department (IHCM) 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 Health Care Management Department at 1-877-693-8271, option 2 or AmeriHealth Caritas Northeast’s Integrated Health Care Management Department at 1-888-208-5966. For Home Infusion care, please call AmeriHealth Caritas Pennsylvania’s Utilization Management Department at 1-800-521-6622 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504.

Some members, due to their exceptional health care needs and family circumstances, may require shift skilled nursing or home health aide services. The Plan’s Shift Care Unit will coordinate Medically Necessary home care needs with the PCP, attending specialist(s), hospital home care departments and other Providers of home care services, for AmeriHealth Caritas Northeast members <21 years of age, for whom home-based shift skilled nursing or home health aide services are requested. For the authorization of Shift Care, please contact the Pediatric Shift Care Unit:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>AmeriHealth Caritas Northeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Shift Care Phone: 1-800-684-5503</td>
<td>Pediatric Shift Care Phone: 1-888-498-0766</td>
</tr>
<tr>
<td>Pediatric Shift Care Fax: 1-866-755-0038</td>
<td>Pediatric Shift Care Fax: 1-888-743-3679</td>
</tr>
</tbody>
</table>

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

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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504.

**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** or AmeriHealth Caritas Northeast’s Utilization Management Department at **1-888-498-0504**.

These steps must be followed by the Health Care Provider:

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

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

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

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

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

The Patient Acknowledgement for Hysterectomy (MA 30) must be attached to the claim when a provider is submitting a claim form for a beneficiary who received a hysterectomy (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. 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 pharmacies and durable medical equipment (DME) suppliers. Such as:
- Vaporizers (one per 365 days)
- Humidifiers (one per calendar year)
- 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

- Diabetic supplies
  - Insulin, disposable insulin syringes and needles
  - Disposable blood and urine testing agents
  - Blood Glucose Meter (Roche® Products), selected Accu-Check meters (one per calendar year).
  - Lancets, control solution and strips (for the above meters)
  - Glucose tablets, alcohol swabs (150 per 34 days).

### Spacers and Peak Flow Meters
- Blood pressure monitors less than $80 are covered by the Plan with a prescription. Coverage is currently limited to one (1) unit per 365 days. Requests that exceed these limits should be referred to the Utilization Management Department for medical necessity review.
- Spacers are covered under the Plan’s pharmacy benefit. Quantity limits are two per calendar year. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Peak flow meters (one per calendar year). Requests that exceed these limits should be referred to the Utilization Management Department for medical necessity review.
- For current price and quantity limits, or to request school supply or replacement of a lost device, contact AmeriHealth Caritas Pennsylvania Pharmacy Services at 1-866-610-2774 or AmeriHealth Caritas Northeast Pharmacy services at 1-888-208-1020.

### 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 or www.amerihealthcaritasnortheast.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 DRG 391, 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 DRG 391 (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** or AmeriHealth Caritas Northeast’s Utilization Management Department at **1-888-498-0504** 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 coordinate necessary arrangements between the PCP, the referring facility, the Nursing Facility, and the Options Assessment Program in order to provide the needed care.

The Options Assessment Program was implemented by DHS to identify individuals who are reviewed by the Options Assessment Unit and considered eligible for long-term care using two criteria: (1) must be over 18 years of age and (2) meet the criteria for nursing home level of care. Once the Options Assessment is completed 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 Options Assessment. Network Providers are responsible for contacting the Area Agency on Aging to initiate an Options Assessment 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 1-717-344-9296
- Berks County Office of Aging 1-610-478-6500
- Cameron County Office of Aging 1-800-672-7145
- Clarion County Office of Aging 1-814-226-4640
- Clearfield County Office of Aging 1-800-255-8571
- Crawford County Office of Aging 1-800-321-7705
- Cumberland County Office of Aging 1-717-240-6110
- Dauphin County Office of Aging 1-800-238-0058
- Elk County Office of Aging 1-800-672-7145
- Erie County Office of Aging 1-800-769-2436
- Forest County Office of Aging 1-800-281-6545
- Franklin County Office of Aging 1-717-263-2153
- Fulton County Office of Aging 1-717-485-5151
- Huntingdon County Office of Aging 1-814-643-5115
- Jefferson County Office of Aging 1-800-852-8036
- Lancaster County Office of Aging 1-800-801-3070
- Lebanon County Office of Aging 1-717-273-9262
- Lehigh County Office of Aging 1-610-782-3034
- McKean County Office of Aging 1-800-672-7145
- Mercer County Office of Aging 1-800-570-6222
- Northampton County Office of Aging 1-800-322-9269
- Perry County Office of Aging 1-717-582-5128
- Potter County Office of Aging 1-814-544-7315
York County Office of Aging | 1-800-632-9073
Venango County Office of Aging | 1-866-452-4464
Warren County Office of Aging | 1-800-281-6545

**AmeriHealth Caritas Northeast Counties:**
- Bradford County Office of Aging | 1-800-982-4346
- Carbon County Office of Aging | 1-800-441-1315
- Centre County Office of Aging | 1-814-355-6716
- Clinton County Office of Aging | 1-570-323-3096
- Columbia County Office of Aging | 1-570-784-9272
- Juniata County Office of Aging | 1-800-348-2277
- Lackawanna County Office of Aging | 1-570-963-6740
- Luzerne County Office of Aging | 1-570-822-1158
- Lycoming County Office of Aging | 1-570-323-3096
- Mifflin County Office of Aging | 1-800-348-2277
- Monroe County Office of Aging | 1-800-498-0330
- Montour County Office of Aging | 1-570-784-9272
- Northumberland County Office of Aging | 1-570-495-2395
- Pike County Office of Aging | 1-800-233-8911
- Schuylkill County Office of Aging | 1-800-832-3313
- Snyder County Office of Aging | 1-570-524-2100
- Sullivan County Office of Aging | 1-800-982-4346
- Susquehanna County Office of Aging | 1-800-982-4346
- Tioga County Office of Aging | 1-800-982-4346
- Union County Office of Aging | 1-570-524-2100
- Wayne County Office of Aging | 1-570-253-4262
- Wyoming County Office of Aging | 1-570-822-1158

It should be noted, per the Plan’s agreement with DHS, that the Plan will be financially responsible for payment for up to 30 days of nursing home care (including hospital reserve or bed hold days) if a Member is admitted to a Nursing Facility. The Plan Members will be dis-enrolled on the 31st day following the admission date to the Nursing Facility as long as the Member has not been discharged (from the Nursing Facility). On day thirty-one (31), the Nursing Facility should begin billing the MA Program as the Member will be dis-enrolled from the Plan.

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/AmeriHealth Caritas Northeast 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**
The Plan offers a perinatal Case Management program, called Bright Start Maternity Program, to pregnant Members. Included in this program, is the Post-Partum Home Visit. Detailed information about the components of the maternity program can be found in Section IX, Special Needs/Case Management.

The goal of the program is to reduce infant morbidity and mortality among Members. 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 eight weeks post-delivery.

**Obstetrician’s Role in Bright Start Maternity Program**
OB Network Providers play a very important role in the success of the Bright Start Maternity Program, particularly the early identification of pregnant 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
- Completing DHS’s Obstetrical Needs Assessment Form (ONAF), located in the Appendix of the Manual and online in the Provider Forms Section at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) and return within 7 days of the initial prenatal visit by submitting online through the Optum® OB Care website. Using the Optum electronic submission process provides benefits such as:
  - No more faxing.
  - No legibility issues.
  - No incomplete submissions leading to returns to your office.
  - Easy and quick submission of the first prenatal, 28-32 week, postpartum, or an additional risk visit.

**To register and get started submitting electronically visit: obcare.optum.com.**

The OB Care User Guide and link to the OPTUM website is also available at:
[www.amerihealthcaritaspen.png](http://www.amerihealthcaritaspen.com) or [www.amerihealthcaritasnortheast.png](http://www.amerihealthcaritasnortheast.com) →Initiatives →Bright Start → Information, Resources, and Tools

The Plan will continue to accept all other methods of ONAF submission, but we encourage you to use this quick and easy electronic method including:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>8040 Carlson Road, Harrisburg, PA 17112</th>
<th>Fax: 1-866-755-9935</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>8040 Carlson Road, Harrisburg, PA 17112</td>
<td>Fax: 1-855-809-9205</td>
</tr>
</tbody>
</table>
Submit the ONAF form three times during the course of a member’s pregnancy:

1. **First prenatal visit**
   - A complete 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 Bright Start Maternity Department:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Bright Start Maternity Program Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-877-364-6797</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-9528</td>
</tr>
</tbody>
</table>

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

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 abuse resources, including information about Centers of Excellence and resources for pregnant members with substance abuse disorders, please refer to our websites at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) → Providers → Resources → Behavioral health and substance abuse resources or [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) → Providers → Initiatives → Opioid Treatment.

**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** or the AmeriHealth Caritas Northeast Provider Services Department at **1-888-208-7370**.
Outpatient Laboratory Services

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

AmeriHealth Caritas Pennsylvania has selected Quest Diagnostics, Inc. as our preferred independent lab provider and may be indicated on the Member's ID card.

- **QUEST** indicated on the member's ID card means labs must be processed through Quest Diagnostics Network
- Physicians are encouraged to perform venipuncture in their office. Providers should then contact Quest Diagnostics to arrange pick-up service.
- For offices that do not have a Quest Diagnostics account, the member should be directed to a Quest Diagnostics Patient Service Center.

For a list of Centers or to become a draw site, contact Quest Diagnostics at: [www.questdiagnostics.com](http://www.questdiagnostics.com) or by calling 1-800-825-7380.

For Member ID cards with no lab indicated, Primary Care Providers and Specialist Providers may utilize any Plan-participating hospital outpatient laboratory or Quest for lab tests or processing of lab specimens.

- 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 PA.

- **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 AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 or go to [www.questdiagnostics.com](http://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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania Utilization Management</th>
<th>1-800-521-6622</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast Utilization Management</td>
<td>1-888-498-0504</td>
</tr>
</tbody>
</table>

to obtain an authorization.

**Pediatric Preventive Health Care Program**

**Known as 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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com)):

- Children ages birth through 30 months should have screening visits at the following intervals: by 1 month, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
- 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 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 several attempts, as an effort of good faith, to contact the requesting Network Provider to discuss the case. If the request is denied in full or in part, a letter detailing the rationale for the decision will be sent to the Member, the requesting Network Provider, and if identified, the provider of service or advocate working on the behalf of the Member. This letter will also contain information regarding 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, Z00.121 or Z00.129 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)

<table>
<thead>
<tr>
<th>New Patient:</th>
<th>Established Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 Age &lt; 1 yr</td>
<td>99391 Age &lt; 1 yr</td>
</tr>
<tr>
<td>99382 Age 1-4 yrs</td>
<td>99392 Age 1-4 yrs</td>
</tr>
<tr>
<td>99383 Age 5-11 yrs</td>
<td>99393 Age 5-11 yrs</td>
</tr>
<tr>
<td>99384 Age 12-17 yrs</td>
<td>99394 Age 12-17 yrs</td>
</tr>
<tr>
<td>99385 Age 18-20 yrs</td>
<td>99395 Age 18-20 yrs</td>
</tr>
</tbody>
</table>

**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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.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

<table>
<thead>
<tr>
<th>UB-04</th>
<th>CMS 1500</th>
<th>Item</th>
<th>Description</th>
<th>C/R</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>10d</td>
<td>Reserved for Local Use EPSDT Referrals</td>
<td>Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen.</td>
<td>C/R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YD – Dental <em>(Required for ages 3 and over)</em></td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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 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.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YV – Vision</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YH – Hearing</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YB – Behavioral</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YM – Medical</td>
<td>C</td>
</tr>
<tr>
<td>18</td>
<td>N/A</td>
<td>Condition Codes</td>
<td>Enter the Condition Code A1 EPSDT</td>
<td>R</td>
</tr>
<tr>
<td>67</td>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>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. <strong>An appropriate diagnosis code must be included for each referral.</strong> Immunization Codes are not required. <strong>EXCEPTION</strong> 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</td>
<td>R</td>
</tr>
</tbody>
</table>
secondary field when submitting an EPSDT screen performed in an inpatient hospital setting

<table>
<thead>
<tr>
<th></th>
<th>Revenue code</th>
<th>Enter Revenue Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>N/A</td>
<td>Code 510</td>
<td>R</td>
</tr>
<tr>
<td>44</td>
<td>24D</td>
<td>Procedures, Services or Supplies CPT/HCPCS Modifier</td>
<td>Populate the first claim line with the age appropriate E &amp; M codes along with the EP modifier when submitting a “complete” EPSDT visit, as well as any other EPSDT related services, e.g., immunizations</td>
</tr>
</tbody>
</table>

**N/A 24H EPSDT/Family Planning Enter Visit Code 03 when providing EPSDT screening services.**

**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.

**Additional EPSDT Information**

**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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.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 referral is required according to the periodicity schedule. *The provider should then contact AmeriHealth Caritas Pennsylvania Member Services Department at 1-888-991-7200 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200 while the member is in the office, or within four (4) business days to notify them that the child is due for a dental referral as part of a complete EPSDT screen. This notification constitutes the provider’s referral to a dental home. The Plan 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 the EPSDT Referral Code YD should be entered in Field 10d on the CMS 1500 claim form or Field 37 on the UB-04 form.

**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

For information on the Early Intervention System, please refer to the Special Needs and Case 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. A full explanation of Tanner observations and scoring is included the Appendix of the Manual.
- 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 Case 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](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) → Resources → EPSDT for an electronic copy

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 codes for these services:

<table>
<thead>
<tr>
<th>Billable Service</th>
<th>CPT Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Screening</td>
<td>83655</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

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 1-855-300-8334.

**Gonorrhea, VDRL, Chlamydia and Pap Smear**
These tests are to be performed when, in the judgment of the PCP, they are appropriate. Adolescents should be questioned about sexual activity and given 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 or www.amerihealthcaritasnortheast.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**

<table>
<thead>
<tr>
<th>Pharmacy Services</th>
<th>Phone:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania Pharmacy Services</td>
<td>1-866-610-2774</td>
<td>1-888-981-5202</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast’s Pharmacy Services</td>
<td>1-888-208-1020</td>
<td>1-855-446-7905</td>
</tr>
<tr>
<td>AmeriHealth Caritas Pennsylvania Opioid Information Line</td>
<td>1-800-578-0898</td>
<td>1-877-708-9080</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast’s Opioid Information Line</td>
<td>1-888-208-1020</td>
<td>1-877-693-8242</td>
</tr>
</tbody>
</table>
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 "Benefit Limit and Co-payment Schedule" in Section I of this Manual and at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com.

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.

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 or http://www.amerihealthcaritasnortheast.com/pharmacy/index.aspx

Members can receive up to a 34-day supply or 150 units of a covered pharmaceutical product, whichever is less, per prescription order or refill. Select generic medications are eligible to be filled for a 90 day supply. Prescriptions written for greater than 150 units require authorization. Please refer to the “Pharmacy Prior Authorization Process” located in this Section of the Manual.

To provide a means of accessing their prescription drug benefit, the Plan has formed a proprietary retail pharmacy Network. This business model allows the Plan to directly credential, communicate with and audit both independent and chain pharmacies providing products and services to our Members.

**Drug Formulary**

The Plan’s drug benefit has been developed to cover Medically Necessary prescription products. The pharmacy benefit is designed to provide for outpatient prescription services that are appropriate, Medically Necessary and is not likely to result in adverse medical outcomes.

The Plan’s Formulary and Prior Authorization process are key components of the benefit design. The medications included in the Formulary are reviewed and approved by the Pharmacy and Therapeutics Committee and the Department of Human Services (DHS). The Pharmacy and Therapeutics Committee includes consumer-designated physicians and pharmacists actively participating in 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 peer reviewed medical literature.

The Pharmacy and Therapeutics Committee meets regularly to review and revise the Formulary. The Formulary Addition/Deletion/Modification Request Form may be found on the Plan websites at www.amerihealthcaritaspenasylvania.com or www.amerihealthcaritasnortheast.com →Providers→ Resources→ Provider Forms.

Providers may request addition of a medication to the Formulary by filling out the Formulary Addition/Deletion/Modification Request Form and forwarding it to:

AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast Pharmacy and Therapeutics Committee
The most up-to-date Formulary is available online in the Provider Center at the AmeriHealth Caritas Pennsylvania Provider Center at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com). Copies are available to Providers and Members upon request. Please contact the AmeriHealth Caritas Pennsylvania’s Provider Services Department at **1-800-521-6007** or AmeriHealth Caritas Northeast’s Provider Services Department at **1-888-208-7370** to request additional copies of the Formulary.

**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). Claims for drugs that require prior authorization will only pay at the point of sale if a prior authorization has been approved by the plan.

To contact the Pharmacy Services Department:

<table>
<thead>
<tr>
<th><strong>AmeriHealth Caritas Pennsylvania</strong></th>
<th><strong>AmeriHealth Caritas Northeast</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Services Phone Number: 1-866-610-2774 between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST)</td>
<td>Pharmacy Services Phone Number: 1-888-208-1020 between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST)</td>
</tr>
<tr>
<td>Member Services Phone Number: 1-888-991-7200 After business hours, Saturday, Sunday and Holidays</td>
<td>Member Services Phone Number: 1-855-809-9200 After business hours, Saturday, Sunday and Holidays</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>AmeriHealth Caritas Pennsylvania Opioid Information Line</strong></th>
<th><strong>AmeriHealth Caritas Northeast’s Opioid Information Line</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: <strong>1-800-578-0898</strong></td>
<td>Phone: <strong>1-888-208-1020</strong></td>
</tr>
<tr>
<td>Fax: <strong>1-877-708-9080</strong></td>
<td>Fax: <strong>1-877-693-8242</strong></td>
</tr>
</tbody>
</table>

The Prior Authorization procedure is as follows:

- The prescriber contacts the Plan by:
  1. Web submission under Pharmacy Services on [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com);
  2. Telephone: ACP=1-866-610-2774, ACN=1-888-208-1020
  3. Fax: ACP=1-855-446-7905, ACN=1-888-981-5202

Pharmacy Services will contact the prescribing provider to inform him or her of the decision within 24 hours of the request’s submission.

Member Services may be contacted for clinical issues after business hours, Saturdays, Sundays, and Holidays by telephone:

<table>
<thead>
<tr>
<th><strong>Member Services Phone Number: 1-888-991-</strong></th>
<th><strong>Member Services Phone Number: 1-855-809-</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Request Prior Authorization for non-Formulary, non-covered agents, or those designated pharmaceutical agents outlined in the Formulary as requiring Prior Authorization
• Utilizing criteria approved by both The Plan's Pharmacy and Therapeutics Committee and DHS, (hereafter referred to as "Approved Criteria"), a 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 of up to twelve months for most medications, or for the length of the prescriber’s request, whichever is shorter
• When the Prior Authorization request does not meet the Approved Criteria, the request is forwarded to a Plan Medical Director for review. In evaluating the request, the Medical Director generally relies upon information supplied by the prescribers, the Medical Director’s medical expertise, guidelines published in the Physicians’ Desk Reference, and accepted clinical practice guidelines
• In the event of insufficient information provided by the prescriber, a Plan pharmacist will attempt to contact the prescriber to obtain the necessary clinical information for review:
  o 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.
• In addition, the decision will comply with the following statutory and regulatory requirements:
  o Medical Assistance Bulletin 03-94-03
  o The Social Security Act
  o OBRA ’90 guidelines
  o Any other applicable state and/or federal statutory/regulatory provisions

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 deems 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 deems it safe for the member to take.
• The Plan will review all 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 submission. The provider informs the Member of the approval.
For those requests that cannot be approved by a Plan pharmacist, a Plan Medical Director will review each request and make and communicate a determination within 24 hours. In the event of a denial, the Plan will notify the prescriber, the PCP and the Member in writing by fax within 24 hours and will offer the prescriber a Formulary approved alternative. The correspondence will outline specifically all Member and Health Care Provider Appeal rights. If the request is approved by the Medical Director, the Plan will notify the prescriber that the request has been approved.

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 AmeriHealth Caritas Pennsylvania’s Member Services Department at 1-888-991-7200 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200. To speak with a Plan Clinical Pharmacist or Medical Director, please call the Pharmacy Services Department at:

<table>
<thead>
<tr>
<th>Pharmacy Services</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-866-610-2774</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast’s</td>
<td>1-888-208-1020</td>
</tr>
</tbody>
</table>

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.

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 the number above.

### 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)
- Limited use agents
- Regimens that are outside the acceptable standard of care approved by the FDA,
- Some prescriptions that exceed $1,000.00 (with exceptions for high cost formulary medications)
- Self-injectable medications other than formulary insulin, glucagon, glucagon, haloperidol, haloperidol decanoate, fluphenazine, fluphenazine decanoate and Epipen.
- Compounded prescriptions that exceed $500
- Early refills

*Please note: additional drugs in the Formulary require Prior Authorization; consult the Formulary for up-to-date Prior Authorization requirements. Any medication without specific prior authorization criteria is reviewed under the “Non-formulary Medication” criteria.

### Injectable and Specialty Medications
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 include treatments covered under either the pharmacy benefit or...
the medical benefit. These products typically 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’s 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’s Specialty Drug Program and may not require Prior Authorization with the exception of Erythropoietin Stimulating Agents (ESA). Please refer to the ESA Policy located in this section of the Manual. Exceptions include formulary insulin, glucagon, haloperidol, haloperidol decanoate, fluphenazine, fluphenazine decanoate and Epipen. Specific forms for specialty and injectable medications can be found online at:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website/Phone/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td><a href="#">www.amerihealthcaritas.com → Pharmacy</a></td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td><a href="#">www.amerihealthcaritasnortheast.com → Pharmacy</a></td>
</tr>
</tbody>
</table>

The Specialty Drug Program focuses on those medications and treatments that represent a potential high health, economic, or safety impact to the patient. The goal of the program is to control and facilitate utilization and distribution of medication, resulting in improved patient outcomes and minimization of waste. Key aspects of this program are intensive clinical review based upon approved protocols for usage, specialty network management, electronic claims adjudication, and utilization management.

This program provides for specialty medications dispensed through Network specialty or retail pharmacies. Nurse Case Management for bleeding disorders and home infusion medication management are some of the focused-approach facets of this important clinical program. See “Bleeding Disorders Program” in this section of the Manual for additional information.

Health Care Providers should use the drug or class specific prior authorization request forms if available. The order form must be completed in its entirety and faxed to the Plan’s Specialty Drug Management Program at:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Fax number/Phone/Website/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-888-981-5202</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-855-446-7905</td>
</tr>
</tbody>
</table>

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’s 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’s specialty network and should indicate the requested specialty pharmacy on all prior authorization forms. 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 forms can be obtained by calling the Specialty Pharmacy Services Department at:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Phone number/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-866-610-2774</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-1020</td>
</tr>
</tbody>
</table>

They can also be found online in the Provider Center at:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td><a href="#">www.amerihealthcaritaspa.com</a></td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td><a href="#">www.amerihealthcaritasnortheast.com</a></td>
</tr>
</tbody>
</table>

Please feel free to copy these forms as needed. The forms are updated as needed so please check the website for the latest updates.
To speak to a Plan representative about the Specialty Drug Management Program, please call:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>Phone number-1-866-610-2774</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>Phone number-1-888-208-1020</td>
</tr>
</tbody>
</table>

**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, Case 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 Specialty Drug Management Department reviews all requests for factor products administered in a Member’s home or in a Hemophilia Treatment Center in an effort to ensure compliance, minimize product overstocking, and monitor utilization.

The **Bleeding Disorders Nurse Case 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 Case 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 and home health care services.
- Is responsible for regular telephone contact and, if applicable, home site visits 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.
- Is available 24/7 to Specialty Pharmacies 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 Case Manager applies the Case Manager seven domains that represent the essential information that a Case Manager must know:

- Case 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 at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com → Providers → Resources → Provider Forms:
- Physician order/prescription (needed with every request)
- Administration/Bleed logs, if available
- The Provider must submit a completed hemophilia factor order request form and a prescription from the doctor for all initial factor requests.
- 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 other 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 newly marketed monoclonal antibody Hemlibra. A four-week supply is typically approved for patients receiving prophylactic treatment. 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.

Erythropoiesis-Stimulating Agents (ESA) Policy
The Plan’s Claims Department will automatically adjudicate Claims for payment for cumulative monthly amounts of a preferred ESA equal to or less than 50,000 units. Dialysis centers and/or physicians will be required to submit documentation to the Plan’s Specialty Drug Program to establish the medical necessity of cumulative monthly doses of a preferred ESA greater than 50,000 units. With the exception of facilities contracted at a case rate for ESA, units over these amounts require Prior Authorization and will be denied if they are billed without an authorization. Once a specific dose is authorized, it will be approved for up to three months. Dosage increases will require additional Prior Authorization.

The form can be obtained by accessing the Plans’ websites at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com → Pharmacy or by calling Pharmacy Services at:

| AmeriHealth Caritas Pennsylvania Pharmacy Services | Telephone 1-866-610-2774 |
| AmeriHealth Caritas Northeast Pharmacy Services | Telephone 1-888-208-1020 |

Please check the website for the latest forms. Feel free to copy these forms as needed. Completed forms should be faxed to:

| AmeriHealth Caritas Pennsylvania Pharmacy Services | Fax 1-888-981-5202 |
| AmeriHealth Caritas Northeast Pharmacy Services | Fax 1-855-446-7905 |

79
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 AB-rated generic equivalent available. When an approved generic equivalent is available, all prescriptions denoting “Brand Necessary” require Prior Authorization. A Health Care Provider requesting a brand product under these circumstances must include information to substantiate medical necessity for a brand medication, such as documentation of adverse effects of generic alternatives. A limited number of brand name products are excluded from the above Prior Authorization requirement, and include the following NTI (Narrow Therapeutic Index) drugs:

- Thyroid preparations
- Phenytoin
- Digoxin
- Carbamazepine
- Lithium
- Sustained Release Theophylline
- Warfarin

Over-the-Counter Medication
Certain generic over-the-counter medications* are covered by the Plan with a prescription from the prescribing Health Care Provider, including:

- 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 with and without fluoride are covered for Members younger than twenty-one (21) years of age when Medically Necessary
- Oral electrolyte mixtures
- Some prenatal vitamins
- Tobacco cessation products

*Covered over-the-counter generic medications can be found on the online formulary at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com
**Vitamin Coverage**

The Plan covers store brand vitamins for Members eligible for pharmacy benefits if Medically Necessary. Members must have a written prescription from a Health Care Provider to get them. The following vitamins are covered:

- Generic single entity and multiple vitamin preparations with or without fluoride for children less than 21 years of age
- Vitamin D and its analogs; nicotinic acid and its analogs; Vitamin K and its analogs; folic acid for members 21 years of age and older
- Generic prenatal vitamins

**Blood Glucose Monitors**

Blood glucose monitors made by Roche®, selected Accu-Chek products are covered with a prescription for Plan Members with diabetes.

Meters, strips, lancets and control solution may be prescribed for members with diabetes and filled at all participating network pharmacies. Pregnant Members and Members being managed on insulin, GLP-1 agonists or amylin analogs products are eligible for 100 strips per month. Members being managed on oral products (non-insulin users) are eligible for 50 strips per month.

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.

**Medication Covered by Other Insurance**

As an agent of the Commonwealth of Pennsylvania Medical Assistance Program, the Plan is always the payer of last resort in the event that a Member receives medical services or medication covered by another payer 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.

**Non-Covered Medications**

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

- Drugs and other items prescribed for any of the following: obesity, anorexia, weight loss, weight gain, or appetite control unless the drug or item is prescribed for any medically accepted indication other than obesity, anorexia, weight loss, weight gain or appetite control
- Drugs for hair growth or other cosmetic purposes
- Drugs that promote fertility
- Non-legend drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes and similar items with the exception of products for tobacco cessation
- Pharmaceutical services provided to a hospitalized person
- Single entity and multiple vitamin preparations except for those listed above
- Drugs and devices classified as experimental by the FDA or not approved by the FDA
- Placebos
- Non-legend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, and other personal care and medicine chest items
- Non-legend aqueous saline solution
- Non-legend water preparations
- Non-legend drugs not covered by the MA Program
- Items prescribed or ordered by a Health Care Provider who has been barred or suspended from participating in the MA Program
• DESI drugs and identical, similar or related products or combinations of these products
• Legend or non-legend drugs when the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
• Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted because of improper utilization or abuse
• Non-legend impregnated gauze and any identical, similar, or related non-legend products
• Any pharmaceutical product marketed by a drug company which has not entered into a rebate agreement with the Federal Government as provided under Section 4401 of the Omnibus Reconciliation Act of 1990
• Drugs prescribed for the treatment of Sexual or Erectile Dysfunction (ED)

Information Available on the Web

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 or http://www.amerihealthcaritasnortheast.com/pharmacy/index.aspx

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.

The following reference materials are available in the Provider Center on the Plan websites: www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com.

Searchable Formulary
• Online Prior Authorization request form
• Drug Specific Physician Injectable Drug request forms
• Physician Chemotherapy Drug request form
• Patient Self-Administered Injectable and Specialty Drugs Request form

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 abuse resources, including information about Centers of Excellence and resources for pregnant members with substance abuse disorders, please refer to our websites at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com → Providers → Resources → Behavioral health and substance abuse resources.

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

Podiatry Services/Orthotics
Network Providers may dispense any Medically Necessary orthotic device compensable under the MA Program upon receiving Prior Authorization from the Plan's Utilization Management
Department. Questions regarding an item should be directed to AmeriHealth Caritas Pennsylvania’s Provider Services Department at 1-800-521-6007 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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 Northeast’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).

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

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

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

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting a Present on Admission section for details.

- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

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

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

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

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 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, Case Management/Care Coordination, Special Care Unit, 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, pharmacy 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 XII of this Manual.

**Radiology Services**

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

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

To request prior authorization contact the Plan’s radiology benefits vendor (NIA via their provider web-portal at [www.radmd.com](http://www.radmd.com) or by calling:
The ordering physician is responsible for obtaining a Prior Authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by NIA and the ordering physician should have this information available at the time of the call.

**Weekend, Holidays and After-Hours Requests**
Requests can be submitted online at [www.radmd.com](http://www.radmd.com)- the NIA web site is available 24 hours a day to providers.

Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to NIA and a message may be left at the numbers given above, which will be retrieved the following business day, which will be retrieved the following business day. Requests left on voice mail:
- NIA will contact the requesting Provider’s office within one business day of receipt of the voice mail request to obtain necessary demographic and clinical information to process the request.

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

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

**Rehabilitation**
If a 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504.

**Reporting Communicable and Incommunicable 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 23 PA Code, Chapter 27. The full text of these rules can be found at: [Reporting Communicable and Incommunicable Diseases (Chapter 27)](http://www.doh.pa.gov).

**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 for an Abortion and the 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 or AmeriHealth Caritas Northeast's Provider Services Department at 1-888-208-7370.
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 1-800-328-4728 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 $25.00; 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 $40.00, whichever is less.
- If prescription contact lenses are chosen, the Plan will pay for the cost of the prescription lenses or $75.00, 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):
Routine eye exams are covered twice every calendar year, and a co-pay may be applicable. Members may receive up to two additional eye exams if the eye doctor completes a form. The Plan does not cover prescription eyeglasses or prescription contact lenses for Members 21 years of age and older with the exception that there are special provisions for Members with aphakia, and cataracts.

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.

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
The Plan 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 a Welcome Package to the Member.

The Plan Identification Card
The plastic Plan Identification Card lists the following information:

- Member’s Name
- Identification Number with a 3 digit alpha prefix (YXM)*
- Member’s Sex and Date of Birth
- State ID Number
- PCP’s Name and Phone Number
- Lab Name
- Co-pays

Welcome Packet
The Plan’s Welcome Packet includes:

- New Member Welcome Letter
- Information about the Member Handbook, what it contains and how to access it online or receive a hard copy
- HIPAA Notice of Privacy Practices and Summary
- A Self-Assessment Health Survey
- Benefits Grid
- Member Copayment Schedule
- Important telephone numbers
- Information about what is available on the Plan’s Web site
- Magnet with important numbers
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 90 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 AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504; Or (2) the Member must contact AmeriHealth Caritas Pennsylvania’s Member Services Department at 1-888-991-7200 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200.

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 ACCESS Card.
- It is important to note that the Plan ID cards are not dated and do not need to be returned to the plan should the 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 through any of the following methods:

1. Internet: NaviNet (www.navinet.net). This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to the Plan.
   - For more information or to sign up for access to NaviNet visit the Provider Center at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com or www.navinet.net or call NaviNet Customer Service at 1-888-482-8057.
2. The Plan’s Automated Eligibility Hotline: AmeriHealth Caritas Pennsylvania’s Provider Services Department at **1-800-521-6007** or AmeriHealth Caritas Northeast’s Provider Services Department at **1-888-208-7370**: Provides immediate real-time eligibility status with no holding to speak to a representative.

- Verify a Member's coverage with the Plan by their Plan identification number, Social Security Number, name, birth date or Medical Assistance Identification Number
- Obtain the name and phone number of the Member’s PCP

3. PROMISe

- Visit [www.promise.DHS.state.pa.us](http://www.promise.DHS.state.pa.us) and click on PROMISe Online
- MA HIPAA compliant PROMISe software (Provider Electronic Solutions Software) is available free-of-charge by downloading from the OMAP PROMISe website at: [www.promise.DHS.state.pa.us/ePROM/providersoftware/softwaredownloadform.asp](http://www.promise.DHS.state.pa.us/ePROM/providersoftware/softwaredownloadform.asp)

4. Pennsylvania Eligibility Verification System (EVS):
**1-800-766-5387**, 24 hours/7 days a week.

- If a Member presents to a Provider’s office and states he/she is a Medical Assistance recipient, but does not have a PA 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.
- The plastic “Pennsylvania ACCESS Card” has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS

**Monthly Panel List**

Below is an example of the monthly panel list sent to PCPs. The monthly panel list is also available on NaviNet at [https://navinet.navimedix.com/Main.aspx](https://navinet.navimedix.com/Main.aspx). The member names below are for demonstration purposes only and do not represent actual members/patients

**Sample Panel List**

All information on this sample is fictitious

<table>
<thead>
<tr>
<th>Member ID#</th>
<th>Recipient#</th>
<th>DOB</th>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
<th>Age</th>
<th>Gender</th>
<th>Other Ins</th>
<th>Date Eff On Panel</th>
<th>V*</th>
<th>Provider Name/No</th>
<th>N*</th>
<th>Restriction</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111111</td>
<td>1010101010</td>
<td>5/2/2002</td>
<td>Abdul, Abba</td>
<td>2223 Warren St</td>
<td>215-999-9999</td>
<td>3m</td>
<td>M</td>
<td></td>
<td>5/2/2002</td>
<td></td>
<td>J Brown</td>
<td>11223344</td>
<td>Y</td>
<td>English</td>
</tr>
<tr>
<td>37777777</td>
<td>6070707070</td>
<td>8/31/1986</td>
<td>Absent, Carol</td>
<td>8787 Cookie Ln</td>
<td>215-999-9999</td>
<td>15</td>
<td>F</td>
<td></td>
<td>6/1/2001</td>
<td></td>
<td>B Hamster</td>
<td>11777577</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62000000</td>
<td>3060606060</td>
<td>4/21/1996</td>
<td>Candy, Frank</td>
<td>251 Bleak Rd</td>
<td>215-444-4444</td>
<td>6</td>
<td>F</td>
<td></td>
<td>8/12/02</td>
<td></td>
<td>J Brown</td>
<td>11223344</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
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

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 Recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the Recipient’s gaining CHC-MCO coverage begin date is the first (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 CHICH-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:
- The Plan is responsible for nursing facility coverage for Plan Members through the first 30 days and any additional days up to and including the day a Member is determined to be eligible for CHC.
- If a Member is determined to be eligible for CHC and covered by the Plan, the nursing facility may then bill the Plan for services for day 31 and ongoing, including the day the Member is determined to be CHC eligible.
- If a Member is determined ineligible for CHC, the Member will remain with Plan for coverage of their physical health services, excluding the nursing facility payment for day 31 and ongoing.
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 his/her 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 20, 2015. 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 2, 2015, for retroactive coverage back to April 10, 2015, and the MA computer database is updated on June 2, 2015, the Plan will resume responsibility for the Member June 2, 2015.

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/MR)
- Residential Treatment Facilities (RTF) within in the South East HealthChoices Zone
- Extended Acute Psychiatric Facilities
- Home and Community Based Waiver Program eligibles
- Nursing Home Residents with other Related Conditions (OSP/PBRA)
- Home and Community Based Waiver Program eligibles for Attendant Care Services (OSP/AC)
- Community Based Services Waiver Program (2176 Waiver)

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

The Plan will provide medical services to Members residing in, or participating in, the following residential facilities or programs for the period of time indicated:

- Nursing Homes - maximum of thirty (30) days
- Juvenile Detention Centers (JDC) - maximum of thirty-five (35) consecutive days
- Pennsylvania Department of Aging (PDA) Waiver Program - maximum thirty (30) consecutive days from the date of enrollment in the program

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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 upon identification of any incarcerated Member.

Pennsylvania ACCESS Card

Individuals eligible for benefits from DHS are issued a Pennsylvania ACCESS Card (“ACCESS Card”). The recipient uses the 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 ACCESS Card to "access" all other DHS benefits.

The plastic 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 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 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 ACCESS Card. Simply verify the recipient’s eligibility via DHS's website, http://promise.DHS.state.pa.us, 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 VII of this Manual.

DHS may have to disenroll a Member from the Plan. The Member may receive health care coverage through DHS’s Community HealthChoices program if:

- The Member is in a skilled Nursing Facility for more than thirty (30) days and is determined to be Nursing Facility Clinically Eligible (NFCE).
- The Member is enrolled in the Pennsylvania Department of Aging (PDA) Waiver program for more than 30 days
- The Member becomes eligible for Medicare and is 21 years of age and older

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 – www.navinet.net

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

NaviNet Supports Pre-Visit Functions

- Eligibility and Benefits Inquiry
  ✓ Real-time access to 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 following information:
    ▪ Demographic information
    ▪ Chronic conditions
    ▪ ER Visits (within the past 6 months)
    ▪ Inpatient Admissions (within the past 12 months)
    ▪ Medications (within the past 6 months)
    ▪ Office Visits (within the past 12 months)

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

NaviNet Supports Patient/Provider Visits

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

- Member Clinical Summary (see Pre-Visit section above)

Prior Authorization Submission through JIVA (for detailed information, Frequently Asked Questions and training materials on JIVA, visit AmeriHealth PA Medical Assistance Plan Central on NaviNet.

- Access JIVA, a web-based functionality that enables you to:
  - electronic referrals Request inpatient, outpatient, home care and DME services
  - Submit extension of service requests
  - Request prior authorization
  - Verify elective admission authorization status
  - Receive admission notifications and view authorization history
  - Submit clinical review for auto approval of requests to service

NaviNet Supports Claims Management Functions

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

NaviNet Supports Back Office Functions

- Panel Roster
  - Mirrors the report primary care providers receive in the mail
  - Provides easy and immediate access
  - Contains panel report plus historical reports for the past six months
  - Reports can be imported into Excel for sorting and/or mailing to targeted patients
  - Reports can be integrated with your practice management system

- Intensive Case Management Reimbursement 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

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 or www.amerihealthcaritasnortheast.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

AmeriHealth Caritas Northeast’s payer ID is 77001
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, Change Healthcare (formerly Emdeon) Business Services
For detailed information and instructions log on to www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com and click on the EFT link or call 1-866-506-2830.

ERA – Call Change Healthcare customer service to sign up for electronic remittance advice at 1-877-363-3666.

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 AmeriHealth Caritas Pennsylvania's Provider Services Department/Claim Service Unit at 1-800-521-6007 or AmeriHealth Caritas Northeast's Provider Services Department/Claim Service Unit at 1-888-208-7370 or look on line at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com.

Provider Network Management/Provider Contracting

The Contracting 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. The primary contact for Network Providers with the Plan is the Provider Account Executive. Provider Account Executives are responsible for orientation, continuing education, and diplomatic problem resolution for all Network Providers. A Provider Account Executive will act as your liaison with the Plan.
Provider 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.

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

Provider Contracting, in collaboration with the Patient Care 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 Northeast.

Call your Provider Account Executive to:
- Arrange for orientation or in-service meetings for Network Providers or staff
- Arrange a service call
- 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 Northeast

Network Providers are strongly encouraged to contact their Provider 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:

| AmeriHealth Caritas Pennsylvania Website | www.amerihealthcaritaspa.com |
| AmeriHealth Caritas Northeast Website    | www.amerihealthcaritasnortheast.com |

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices must be made on the Provider Change Form. The form is located in the Appendix of the Manual or can be found on the Provider Center of:

| AmeriHealth Caritas Pennsylvania Website | www.amerihealthcaritaspa.com |
| AmeriHealth Caritas Northeast Website    | www.amerihealthcaritasnortheast.com |

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

Provider Contracting Department  
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 or AmeriHealth Caritas Northeast's Provider Services Department at 1-888-208-7370.

- 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 AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200:

- 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 Needs services
- Ask for health education materials in other languages 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 Practitioner (PCP) & Specialist Office Standards & Requirements
Responsibilities of All Providers

Providers who participate in the Plan have responsibilities, including but not limited to:

- Be compliant with all applicable Federal and/or state regulations.
- Treat 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.
- As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs members 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 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 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.
• 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.
• 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.

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;
• 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 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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Rapid Response and Outreach Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-800-684-5503</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-855-859-4110</td>
</tr>
</tbody>
</table>

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 Plan’s dedicated web page to child abuse prevention at AmeriHealth Caritas Provider Center at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.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: [http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/index.htm](http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/index.htm)

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 Competency 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
Division of Immunizations
Room 1026
Health and Welfare Building
7th and Forster Streets
Harrisburg, PA 17120
Toll Free: 1-888-646-6864
Telephone: 717-787-5681
e-mail: paimmunizations@state.pa.us

PCP Reimbursement

PCP Fee-For-Service Reimbursement
Fee-for-service PCP reimbursement is a payment methodology used by the Plan. If contracted under this methodology, practitioners are required to bill for all services performed in the primary care office. Reimbursement is in accordance with the Fee-for-Service Compensation schedule that is included in the Provider’s contract.

Capitation/Above-Capitation Reimbursement
PCPs capitation reimbursement is a monthly Capitation payment that is based on the age and gender of the Members assigned to their panels. After monitoring monthly enrollment and disenrollment from each PCPs 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 Provider Center at www.amerihealthcaritaspa.com or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.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 the AmeriHealth Caritas Provider Center at www.amerihealthcaritaspa.com or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.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

<table>
<thead>
<tr>
<th>From Age</th>
<th>To Age</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 yrs.</td>
<td>&lt; 1 yr.</td>
<td>M/F</td>
</tr>
<tr>
<td>1 yr.</td>
<td>&lt; 2 yrs.</td>
<td>M/F</td>
</tr>
<tr>
<td>&gt; 2 yrs.</td>
<td>&lt; 4 yrs.</td>
<td>M/F</td>
</tr>
<tr>
<td>5 yrs.</td>
<td>14 yrs.</td>
<td>M/F</td>
</tr>
<tr>
<td>15 yrs.</td>
<td>18 yrs.</td>
<td>F</td>
</tr>
<tr>
<td>15 yrs.</td>
<td>18 yrs.</td>
<td>M</td>
</tr>
<tr>
<td>19 yrs.</td>
<td>39 yrs.</td>
<td>F</td>
</tr>
<tr>
<td>19 yrs.</td>
<td>39 yrs.</td>
<td>M</td>
</tr>
<tr>
<td>40 yrs.</td>
<td>64 yrs.</td>
<td>F</td>
</tr>
<tr>
<td>40 yrs.</td>
<td>64 yrs.</td>
<td>M</td>
</tr>
<tr>
<td>65 yrs. &amp; older</td>
<td></td>
<td>M/F</td>
</tr>
</tbody>
</table>

**Legend:**

- `<` = less than
- `>` = greater than
- `M` = male
- `F` = female
- `yr(s)` = years of age

**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

Please refer to the Appendix for the list of procedures reimbursed above Capitation, and in the AmeriHealth Caritas Provider Center at www.amerihealthcaritaspa.com or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com for those services paid in addition to Capitation.

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](http://www.amerihealthcaritaspa.com) and [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com), including but not limited to:
- Online provider directory
- Hospital notification of emergency admission
- Provider change form
- 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**

<table>
<thead>
<tr>
<th>Medical Care:</th>
<th>Plan Standard:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care must be scheduled (<a href="https://www.amerihealthcaritaspa.com">health assessment/general physical examinations</a> and first examinations)</td>
<td>Within 3 weeks of the Member’s Enrollment</td>
</tr>
<tr>
<td>Routine Primary Care must be scheduled</td>
<td>Within 10 business days of the Member’s call</td>
</tr>
<tr>
<td>Urgent Medical Condition Care must be scheduled</td>
<td>Within 24 hours of the Member’s call</td>
</tr>
<tr>
<td>Emergency Medical Condition Care must be seen</td>
<td>Immediately upon the Member’s call or referred to an emergency facility</td>
</tr>
</tbody>
</table>

**After-Hours Accessibility Standards**

<table>
<thead>
<tr>
<th>Medical Care:</th>
<th>Plan Standard:</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-hours Care by a PCP or a covering PCP must be available *</td>
<td>24 hours/7 days a week</td>
</tr>
</tbody>
</table>

*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 Needs. The Plan asks that PCPs contact all new panel Members for an initial appointment. The Plan has Special Needs and Care Management Programs 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** or AmeriHealth Caritas Northeast’s Bright Start Maternity Program at **1-888-208-9528** 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.)

<table>
<thead>
<tr>
<th>Initial Examination for Members …</th>
<th>Appointment Scheduled with a PCP or Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>with HIV/AIDS</td>
<td>No later than 7 days of the effective date of Enrollment, unless the Member is already being treated by a PCP or Specialist.</td>
</tr>
<tr>
<td>who receive Supplemental Security Income (SSI)</td>
<td>No later than 45 days of Enrollment, unless the Member is already being treated by a PCP or a Specialist.</td>
</tr>
<tr>
<td>under age of 21</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Members who are pregnant**

<table>
<thead>
<tr>
<th>Appointment Scheduled with an OB/GYN practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women in their 1st trimester</td>
</tr>
<tr>
<td>Pregnant women in their 2nd trimester</td>
</tr>
<tr>
<td>Pregnant women in their 3rd trimester</td>
</tr>
<tr>
<td>High-risk Pregnant Women</td>
</tr>
</tbody>
</table>

**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. PCPs must comply with all Cultural Competency 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 Competency.

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

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

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 AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200. 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 IV of the Manual or the Claims Filing Instructions in Section VI.
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 VI 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 or AmeriHealth Caritas Northeast's Provider Services Department at 1-888-208-7370.
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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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 X 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 the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.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 the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com, or call your Provider Account Executive to request a copy.

In support of the above guidelines, the Plan has Disease Management and Case 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 Case Management Services, call AmeriHealth Caritas Pennsylvania’s Provider Services Department at 1-800-521-6007 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 and ask for the Special Needs Department.

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 NaviNet online at www.navinet.net or by calling AmeriHealth Caritas Pennsylvania Provider Services at 1-800-521-6007 or AmeriHealth Caritas Northeast Provider Services at 1-888-208-7370. For more information, please refer to "Referral & Authorization Requirements” in Section II 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 VI 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 or AmeriHealth Caritas Northeast’s Utilization Management Department at 1-888-498-0504 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:

122
• 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 Plan's dedicated web page to child abuse prevention at AmeriHealth Caritas Pennsylvania Provider Center at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com).

**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 business days of the referral
• Routine appointments within 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 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.

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.
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 X of the Manual.

Specialist as a PCP for Special Needs Members
Refer to the Special Needs and Case Management Section for complete details.

PCP & OB/GYN Office Standards

Physical Environment
The Plan conducts an initial office site visit to all potential PCP and OB/GYN sites. Each practice/site location of all PCPs and OB/GYNs must receive a site visit re-evaluation every three years. 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
• Emergency Preparedness
• Treatment Areas
• Medication Administration
• Infection Control
• Medical Record Keeping Practices
• General Information

The following are examples of standards that must be met for Plan network participation:
1. Office must have visible signage and must be handicapped-accessible*
2. Office hours must be posted
3. Office must be clean and presentable
4. Office must have a waiting room with chairs
5. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
6. Office must have at least two examination rooms that allow for patient privacy
7. Office must have the following equipment:
   • Examination table
   • Otoscope
   • Ophthalmoscope
   • Sphygmomanometer
   • Thermometers
   • Needle disposal system
   • Accessible sink/hand washing facilities
   • 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. 1201 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 www.usdoj.gov/crt/ada/adahom1.htm

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.

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 or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com.)

- Elements in the medical record are organized in a consistent manner, and the records are kept secure and confidential
- 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
- 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 abuse (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
- 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
• Health care 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

Medical Record Retention Responsibilities
Medical records must be preserved and maintained for a minimum of five (5) years from termination of the Health Care Provider’s agreement with 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.
Section 6: Claims and Claim Disputes
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 or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com.

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 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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
  P.O. Box 6059
  Fargo, ND 58108-6059

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 all providers must be enrolled in Medicaid in order to be paid by Medicaid. This means all 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.
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 [www.DHS.state.pa.us](http://www.DHS.state.pa.us).

AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast 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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Member Services Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania</td>
<td>1-888-991-7200</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-855-809-9200</td>
</tr>
</tbody>
</table>

COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs 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 Practitioners (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, or 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 Program Integrity department 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 payment or recovery of potential overpayments. You may be asked to provide supporting documentation including the medical record or itemized bill to support the review of the claim. Claims requiring itemized bills or medical records will be denied if the requested supporting documentation is not received timely.
In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer’s submission of similar claims; if this were to occur you would be notified and additional action may be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the 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 record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member’s eligibility changes between when the authorization was issued and the service was provided.

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.

Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $10,957 to $21,915 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies, as well as possible exclusion from Federal Government health care programs. These minimum and maximum penalties have been updated to reflect the Civil Monetary Penalties Inflation Adjustment Interim Final Rule by the Department of Justice published on June 30, 2016, with an effective date of August 1, 2016.

Program Integrity Operations Team
Program Integrity Operations is responsible for the identification, reporting and collection of FWA recoveries. The teams use real time data to identify overpayments, provide specific state or contractual reporting and collect outstanding balances from providers. This team is made up of three sub groups Claims Cost Management, Recoupment and Reporting, Credit Balance; The Internal Claims Cost Management team performs prospective (pre-payment) and retrospective (post-payment) analysis to validate the accuracy of claims payments.

- Prospective analysis - This analysis includes the development of front-end edits to identify potentially inaccurate payments, prior to payment of the claim. The team coordinates the correction of the claim payment with The Plan’s claims processing unit.
- Retrospective analysis - The team performs first-pass retrospective review of paid claims. Retrospective edits help us identify potential overpayments of professional, outpatient, and facility claims; we then submit these for recovery of the overpayment.

The Recoupment and Reporting team develops and distributes both internal, plan and state reports related to FWA services. This team acts as the gatekeeper of all FWA inventory accountable for intake, management, and monitoring of overpayment recovery projects. This team uses a system called CORS (claim overpayment recovery system) to track and report all related activity.

The Credit Balance team pursues outstanding provider credit balances that exist for more than 60 days. They perform provider outreach through outbound calls and letter mailings.

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
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 or AmeriHealth Caritas Northeast
Claims Cost Containment
PO 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)(4)(B), overpayments must be reported and returned to within sixty (60) days of identification. Section 6402(a) of the Affordable Care Act clarifies that a failure to timely report and return overpayments will be considered an obligation, as defined in the False Claims Act (“FCA”). Providers who knowingly conceal or knowingly and improperly avoid or decrease an obligation 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 or AmeriHealth Caritas Northeast Provider Claims Services at 1-888-208-7370 to arrange the repayment. There are two ways to return overpayments to The Plan:
   - Have The Plan deduct the overpayment/improper payment amount from future claims payments, or
   - Return the overpayments directly to The Plan:
     - 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 or www.amerihealthcaritasnortheast.com → Providers→ Resources →Provider Forms
     - Mail the completed form and refund check for the overpayment/improper payment amount to:
       AmeriHealth Caritas Pennsylvania or AmeriHealth Caritas Northeast
       ATTN: Provider Refunds
       PO 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:
Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste or Abuse

Special Investigations Unit
AmeriHealth Caritas and AmeriHealth Caritas Northeast 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 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. 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 – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.

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 – includes provider reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the health program.

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 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.

**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 www.pacode.com/secure/data/055/partIltoc.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 Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services. As part of 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 Correction 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 contractors, 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 $10,957 to $21,915 per false 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 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 and AmeriHealth Caritas Northeast.
- 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, 200 Stevens Drive, Philadelphia, PA, 19113.

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: 866-DHS-TIPS (866-347-8477)
- On-line: www.dhs.pa.gov/learnaboutdhs/fraudandabuse/
- Fax: 1-717-772-4655, Attn: MA Provider Compliance Hotline
- Mail: Department of Human Services
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 Unit or (3) the federal Office of Inspector General for further investigation. You may receive an overpayment letter that outlines what was found and if monies are owed. You could also receive an education letter that outlines proper procedures that are to be followed for future reference. You could be placed on prepayment review.

Claim Disputes and Appeals

The Plan’s goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. 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/AmeriHealth Caritas Northeast
P.O. Box 7118
London, KY 40742

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 (ten or less), the Network Provider can call AmeriHealth Caritas Pennsylvania’s Provider Services Department at 1-800-521-6007 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 to report payment discrepancies. Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Emergency Department Payment Level Reconsideration for Participating Providers
In certain cases, it is not necessary for a hospital Provider to appeal a Claim decision when they are not in agreement with the Plan’s level of payment for Emergency Room services. If a Claim has been reimbursed at the lower degree of acuity rate, and the original Claim submission did not include medical records or the Emergency Room summary, the hospital Provider may resubmit the Claim along with medical records (or Emergency Room Summary) for payment level reconsideration. The Plan’s clinical staff will review the medical records and render a decision based on the nature of treatment rendered to treat presenting symptoms. These Claims should be submitted to the Claims Medical Review Department at the following address:

Claims Medical Review Department
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
P.O. Box 7118
London, KY 40742

Hospital Providers will be notified via the remittance advice of any decisions to pay at the higher degree of acuity rate. If review of the medical records does not indicate services should be paid at the higher degree of acuity rate, a letter will be sent to the hospital Provider upholding the original Claim determination.
If the hospital Provider disagrees with this determination, the hospital Provider may file a Formal Provider Appeal for further reconsideration of the level of payment. For information on how to file, please refer to Formal Provider Appeal procedures outlined in Section VII.

**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 II 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 following procedures may be followed.

**Claims Disputes**

**What is a Dispute?**

A Dispute is 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.

Claims Disputes include Claim denials, payments the Network Provider feels were made in error by the Plan, or involve a larger volume of Claims than cannot easily be handled by phone. Network Providers must submit these Claims Disputes to the Plan within 365 days from the date of service, or the date compensable items were provided, with a written explanation of the error to:

*AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast*

*Claims Disputes*

*P.O. Box 7118*

*London, KY 40742*

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 VI or online in the Provider Center at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.com. All disputed Claims will be acknowledged, researched and the decision conveyed to the Network Provider within 60 days following procedures as outlined in Section VII. If the Network Provider disagrees with the Plan’s Dispute decision, the Network Provider may file a Formal Provider Appeal if the denial reason was related to medical necessity.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365 day timeframe is exceeded.

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.
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 Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

Examples of Disputes include, but are not limited to:
- Service issues with the Plan, including failure to return a 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

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 AmeriHealth Caritas Northeast's Provider Claims Services at 1-888-208-7370, 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/AmeriHealth Caritas Northeast
Informal Disputes
P.O. Box 7329
London, KY40742

See Section VI, Claims and Claims Disputes, for specific filing requirements related to Claims Disputes.

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).

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 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 involving medical necessity not resolved to the Network Provider’s satisfaction through the Plan’s Informal Provider Dispute Process
- 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 or
(b) do not contain Member consent for a Member Complaint or a consent that conforms to applicable law for a Grievance filed by a Health Care Provider on behalf of a Member (see Provider Initiated Member Appeals in this Section of the Manual for required elements of a Member consent for a Grievance. Note: these requirements do not apply to Complaints.)

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 Health 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.

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 denied for exceeding the 180-day filing time limit may be appealed through the Plan’s Informal Provider Dispute Process outlined in this Manual.
- Denials issued as a result of a Prior Authorization review by 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.
- Provider terminations based on quality of care reasons may be appealed in accordance with the Plan Provider Sanctioning Policy outlined in Section VIII; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section VIII.
- 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 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 appropriate Post Office Box below and must contain the words “First Level Outpatient Formal Provider Appeal”, or “First Level Inpatient Formal Provider Appeal”, as appropriate at the top of the request:
Inpatient Appeal:
Provider Appeals Department
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
P.O. Box 7307
London, KY 40742

Outpatient Appeal:
Provider Appeals Department
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
P.O. Box 7316
London, KY 40742

The Plan will send the Health Care Provider a letter acknowledging the Plan’s receipt of the request for a First Level Appeal Review within ten business days of receipt of the request from the Health Care Provider.

Failure to follow these appeal guidelines may result in your request not being addressed.

**Physician Review of a First Level Appeal**
The First Level Appeal Review is conducted by a board certified Physician Reviewer 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
- Review of 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 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 appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Provider Appeal" or "Second Level Inpatient Formal Provider Appeal", as appropriate, at the top of the request.

Inpatient Appeal:
Provider Appeals Department
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
P.O. Box 7307
London, KY 40742

Outpatient Appeal:
Provider Appeals Department
AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast
P.O. Box 7316
London, KY 40742

The Plan will send the Health Care Provider a letter acknowledging the Plan's receipt of the request for a Second Level Appeal Review within ten business days of receipt of the request from the Health Care Provider.

Appeals Panel Review of a Second Level Appeal
A board-certified Physician Reviewer, who was not involved in the decision-making for the original denial, or prior appeal review of the case, will review the appeal. The Physician Reviewer 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. The Physician Reviewer's recommendation will be provided to the Appeals Panel for consideration and deliberation.

The Appeals Panel is comprised of at least one-quarter (1/4) peer representation. At the request of the Appeals Panel, the Reviewing Physician may present his/her recommendation in person at the Appeals Panel meeting. The panel is comprised of at least three individuals, including one Physician Reviewer in current practice contracted by the Plan but not employed by the Plan (peer representative) and two other management staff from the Plan’s Provider Network Management, Provider Appeals, or Claims Departments.

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
- Review of 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 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 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**

**First Level Complaints**

1. A Complaint is a dispute or objection regarding a Network Provider or the coverage, operations or management policies of the Plan that has not been resolved by the Plan and has been filed with The Plan or the Department of Health or the Insurance Department of the Commonwealth. The term includes, but is not limited to:

   a. The Plan denied a requested service/item because it is not a covered benefit;
   b. The Plan failed to meet the required timeframes for providing a service/item;
   c. The Plan failed to decide a Complaint or Grievance within the specified timeframes;
   d. The Plan denied payment after a service had been delivered because the service/item was provided without authorization by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or
   e. The Plan denied payment after a service had been delivered because the service/item provided is not a covered service/item for the Member
   f. The Plan denied 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.

2. Members or a Member’s representative, which may include the Member’s Health Care Provider, with proof of the Member’s written authorization may file a Complaint within sixty (60) days from the date of the incident complained of or the date the Member receives written notice of the decision if the Complaint involves any of the issues listed in items (a)-(f) in the definition of the term “Complaint” in paragraph 1 above. For all other Complaints, there is no time limit for filing.

3. Upon receipt of the Complaint, The Plan will send the Member and other appropriate parties a DHS approved acknowledgment letter.

4. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person, by telephone or videoconference as well in writing.

5. The Plan will give the Member at least seven (7) days advance written notice of the First Level Complaint review date using the DHS supplied template.
6. If a First Level Complaint is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the First Level Complaint, if the First Level Complaint is made orally, hand delivered or post-marked within ten (10) days from the mail date on the Plan's written notice of the decision. The Plan also honors a verbal filing of a First Level Complaint within ten (10) days of receipt of the written denial decision in order to continue services.

7. The First Level Complaint Review Committee performs the First Level Review. For Complaints not involving a clinical issue, the committee is composed of one or more employees of The Plan who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

8. For Complaints involving clinical issues, the First Level Complaint Review Committee shall include one or more employees of The Plan and a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. The physician on the committee decides the Complaint. All members of the First Level Complaint Review Committee cannot have been involved in nor be subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

9. The First Level Complaint Review Committee completes its review of the Complaint as expeditiously as the Member’s health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by up to fourteen (14) days at the request of the Member if the Complaint involves any of the issues listed in items (a)-(f) in the definition of the term “Complaint” in paragraph 1 above.

10. The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the Complaint record.

11. The Plan sends a written notice, using the template supplied by DHS, of the First Level Complaint Decision to the Member and other appropriate parties, within thirty (30) days from receipt of the Complaint by The Plan, unless an up to fourteen (14) day extension was granted to the Member.

If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

- The Plan denied a requested service/item because it is not a covered benefit;
- The Plan failed to meet the required timeframes for providing a service/item;
- The Plan failed to decide a Complaint or Grievance within the specified timeframes;
- The Plan denied payment after a service had been delivered because the service/item was provided without authorization by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- The Plan denied payment after a service had been delivered because the service/item provided is not a covered service/item for the Member.
- The Plan denied a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

The Member or Member’s representative may file a request for a Fair Hearing within 120 days from the mail date on the written notice of The Plan’s written notice of the First Level Complaint decision.

The Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the
Member’s behalf, may file a request for an external review in writing with either DOH or PID within fifteen (15) days from the date the Member receives written notice of the PH-MCO’s first level Complaint decision.

For all other Complaints:
The Member or Member’s representative, which may include the Member’s Provider, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Member receives written notice of The Plan’s first level Complaint decision.

Second Level Complaints
1. Upon receipt of the Second Level Complaint, The Plan sends the Member and other appropriate parties a DHS approved acknowledgment letter.
2. The Second Level Review for Complaints not involving clinical issues is performed by a Second Level Complaint Review Committee, which is composed of three or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the matter under review.
3. The second level complaint review for Complaints involving clinical issues, must be conducted by a second level Complaint Review Committee made up of three (3) or more individuals who were not involved in are not subordinates of an individual involved in any previous level of review or decision-making that is the subject of the Complaint. The second level Complaint Review Committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the second level Complaint.
4. At least one-third of the Second Level Complaint Review Committee may not be employed by The Plan or a related subsidiary or affiliate.
5. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
6. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person or videoconference as well in writing.
7. The Plan will give the Member at least fifteen (15) days advance written notice of the First Level Complaint review data, using the DHS supplied template. If the Member cannot appear in person at the review an opportunity for the Member to communicate with the second level Complaint Review Committee by telephone or videoconference will be provided.
8. The decision of the Second Level Complaint Review Committee is based solely on the information presented at the review, including all comments, documents, records and other information submitted by the Member or the Member’s representative without regard to whether such information was submitted or considered previously. Testimony taken by the committee (including the Member’s or the Member Representative’s comments) is tape-recorded, or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
9. The Plan sends a written notice, using the template supplied by DHS, of the Second Level Complaint Decision to the Member and other appropriate parties, within forty-five (45) days from the date the second level complaint was received.
10. The Member or Member representative may file a request for an External Review of the Second Level Complaint Decision with either the Department of Health or the Insurance...
Department within fifteen (15) days from the date the Member receives the written notice of The Plan’s Second Level Complaint Decision.

External Complaint Process
1. If a Member or Member Representative files a request for an External Review of a Second Level Complaint Decision to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the External Review, if the request for External Review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of The Plan’s Second Level Complaint Decision.
2. Upon the request of either the Department of Health and/or the Insurance Department, all records from the First Level Review and Second Level Review shall be transmitted to the appropriate department by The Plan within thirty (30) days from the request in the manner prescribed by that department. The Member, Member Representative or the Health Care Provider or The Plan may submit additional materials related to the Complaint.
3. The Department of Health and/or the Insurance Department will determine the appropriate agency for the review.

Expedited Complaints
1. An expedited Complaint review must be conducted if The Plan determines or if a Member or Member’s representative, (with proof of the Member’s written authorization) provides The Plan with certification from the Member’s Provider (including the Provider’s signature) that the Member’s life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. A request for an Expedited Complaint review may be requested either by fax, orally, email or in writing. Upon receipt of a verbal or written request for expedited review, The Plan verbally informs the Member or Member representative of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
2. If an Expedited Complaint is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving on the basis that the service/item is not a covered service/item, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the Expedited Complaint, if the Expedited Complaint is made orally, hand delivered, faxed, emailed or post-marked within ten (10) days from the mail date on the written notice of the decision. A signed Health Care Provider certification stating that the Member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy following the regular Complaint process must be provided to The Plan. The Health Care Provider certification is required regardless of the manner in which the Expedited Complaint is filed. If the Health Care Provider certification is not included with the request for an expedited review, The Plan informs the Member that the Health Care Provider must submit a certification as to the reasons why the expedited review is needed.
3. The Plan makes a reasonable effort to obtain the certification from the Health Care Provider. If the Health Care Provider certification is not received within seventy-two (72) hours of the Member’s request for Expedited Review, The Plan makes a reasonable effort to give the Member prompt verbal notice that the Complaint is to be decided within the standard timeframe (unless the timeframe for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member), and sends a written notice (using the template specified by DHS) within two (2) days of the decision to deny expedited review. If The Plan does not accept an Expedited Complaint because of lack of physician certification in any
form, the Member or Member representative can file a complaint regarding The Plan’s refusal to accept an expedited request. The Expedited Complaint Review Process is bound by the same rules and procedures as the Second Level Complaint Review Process with the exception of timeframes, which are modified as specified in this section.

4. The Expedited Complaint review is performed by the Expedited Complaint Review Committee, which shall include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The member of the Expedited Complaint Review Committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

5. The Plan prepares a summary of the issues presented and decisions made, which is maintained as part of the Expedited Complaint Record.

6. The Plan issues the decision resulting from the Expedited Review in person or by phone to the Member and other appropriate parties within forty-eight (48) hours of receiving the Health Care Provider’s certification or seventy-two (72) hours of receiving the Member’s request for an Expedited Review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to fourteen (14) days at the request of the Member. In addition, The Plan mails written notices of the decision, using the template supplied by DHS, to the Member and appropriate other parties within two (2) business days of the decision.

7. The Member or Member representative may file a request for an Expedited External Complaint review with The Plan within two (2) business days from the date the Member receives The Plan’s Expedited Complaint Decision. The Plan follows Department of Health guidelines when handling requests for Expedited External Complaint Reviews.

**Grievances**

**Grievance Process**

1. A Grievance is a request by a Member, Member representative, or a Health Care Provider, with proof of the member’s written authorization for the representative or Health Care Provider to be involved and/or act on a member’s behalf, to have The Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If The Plan is unable to resolve the matter, a Grievance may be filed regarding a The Plan decision to:

   a. Deny, in whole or in part, payment for a service/item;
   b. Deny or issue a limited authorization of a requested service/item, including a determination based on the type or level of service/item;
   c. Reduce, suspend or terminate a previously authorized service/item;
   d. Deny the requested service/item but approve an alternative service/item
   e. Deny a request for a benefit limit exception (BLE)

   This term does not include a Complaint.

2. Members, Member representatives, and/or Health Care Providers, if the Health Care Providers filed the Grievance with consent, have sixty (60) days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Providers filed the Grievance with consent, receives the written notice of denial to file a Grievance.

3. Upon receipt of the Grievance, The Plan sends the Member and appropriate other parties a DHS approved acknowledgement letter.

4. If a Grievance is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, the Member continues to receive the disputed service/item at
The previously authorized level pending resolution of the Grievance, if the Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.

5. The Grievance review is performed by the Grievance Review Committee, which is made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. At least one-third of the Grievance Review Committee may not be employees of The Plan or a related Affiliate. The Committee must include a licensed physician, in the same or similar specialty that typically manages or consults on the service/item in question. The physician on the committee decides the Grievance.

6. The Member is afforded a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well in writing.

7. The Plan will give the Member at least seven (7) days advance written notice of the review date, using the DHS supplied template. If the Member cannot appear in person at the review an opportunity for the Member to communicate with the Grievance Review Committee by telephone or videoconference will be provided.

8. The Grievance Review Committee completes its review of the Grievance as expeditiously as the Member’s health condition requires. The committee prepares a summary of the issues presented and decisions made, which is maintained as part of the Grievance record.

9. The Plan sends a written notice of the Grievance Decision, using the template supplied by DHS, to the Member and other appropriate parties, within thirty (30) days from receipt of the Grievance by The Plan, unless an up to fourteen (14) day extension was granted by request of the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the grievance with consent may file a request for a Fair Hearing, a request for an external review, or both a request for Fair Hearing and a request for an external review.

10. The Member or Member representative may file a request for a DHS Fair Hearing within one hundred and twenty days (120) from the mail date on the written notice of the Grievance decision.

11. The Member or Member representative may a file a request with The Plan for an external review of a Grievance decision by a certified review entity (CRE) appointed by DOH. The request must be filed in writing or verbally with fifteen (15) days from the date the Member receives the written notice of the Grievance decision.

External Grievances

1. All requests for External Grievance Review are processed through The Plan. The Plan is responsible for following the protocols established by the Department of Health in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member representative, and/or Provider, if the Health Care Provider filed the grievance with consent, service provider and prescribing provider.

2. Within five (5) business days of receipt of the request for an External Grievance Review, The Plan notifies the Member, the Member’s representative (if designated), the Health Care Provider, and the Department of Health that the request for External Grievance Review has been filed.

3. If a Member, Member representative, and/or Health Care Provider, if the Provider filed the Grievance with consent, files an External Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the External Grievance, if the External Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the Grievance decision.
4. The External Grievance Review is conducted by independent medical review entity (CRE) certified by the Pennsylvania Department of Health to conduct External Grievance Reviews.

5. Within two (2) business days from receipt of the request for an External Grievance Review, the Department of Health randomly assigns an independent medical review entity (CRE) to conduct the review. The Plan and assigned CRE entity are notified of this assignment.

6. If the Department of Health fails to select a CRE within two (2) business days from receipt of a request for an External Grievance Review, The Plan may designate a CRE to conduct a review from the list of CRE's approved by the Department of Health. The Plan will not select a CRE that has a current contract or is negotiating a contract with The Plan or its affiliates or is otherwise affiliated with The Plan or its affiliates.

7. The Plan forwards all documentation regarding the decision, including all supporting information, a summary of applicable issues, the basis and clinical rationale for the decision to the CRE conducting the External Grievance Review. The transmission of information takes place within fifteen (15) days from receipt of the Member's request for an External Grievance Review.

8. Within the same fifteen (15)-day period, The Plan will provide the Member or Member's representative or Health Care Provider, if the Health Care Provider filed the Grievance with consent, with a list of documents being forwarded to the CRE for the External Review.

9. Within fifteen (15) days from receipt of the request for an External Grievance Review by The Plan, the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent may supply additional information to the CRE conducting the External Grievance Review for consideration. Copies must also be provided at the same time to The Plan so that The Plan has an opportunity to consider the additional information.

10. Within sixty (60) days from the filing of the request for the External Grievance Review, the CRE conducting the External Grievance Review issues a written decision to The Plan, the Member, the Member’s representative and the Health Care Provider (if the Health Care Provider filed the Grievance with the Member’s consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of The Plan’s contract.

11. The External Grievance Decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent receives notice of the External Grievance Decision.

**Expedited Grievances**

1. An Expedited Review must be conducted if The Plan determines or if a Member or Member’s representative, (with proof of the Member’s written authorization) provides The Plan with certification from the Member’s Provider (including the Provider’s signature) that the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, believes that the Member’s life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the Standard Grievance Process. An Expedited Grievance Review may be requested in writing, by fax, by email or verbally.

2. Upon receipt of a request for Expedited Review, The Plan verbally informs the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

3. If an Expedited Grievance is filed to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving, then the Member will continue to receive the disputed service/item at the previously authorized level pending resolution of the
Expedited Grievance, if the Expedited Grievance is made orally, hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision.

4. A signed Health Care Provider certification that the Member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the Standard Grievance Process must be provided to The Plan. The Health Care Provider certification is required regardless of the manner in which the Expedited Grievance is filed. If the Health Care Provider certification is not included with the request for an expedited review, The Plan informs the Member that the Health Care Provider must submit a certification as to the reasons why the Expedited Review is needed.

5. The Plan makes a reasonable effort to obtain the certification from the Health Care Provider.

6. If the Health Care Provider certification is not received within seventy-two (72) hours of the Member’s request for Expedited Review. The Plan makes a reasonable effort to give the Member prompt verbal notice that the Grievance is to be decided within the standard timeframe (unless the time frame has been extended by up to fourteen (14) days at the request of the Member), and sends a written notice using the DHS supplied template within two (2) days of the decision to deny Expedited Review.

7. If The Plan does not accept an Expedited Grievance because of lack of physician certification in any form, the Member or Member representative can file a Complaint regarding The Plan’s refusal to accept an Expedited Request. Appeal rights are included in The Plan’s letter to the Member/Member representative denying the Expedited Request.

8. The Expedited Grievance Review is performed by the Expedited Grievance Review Committee, made up of three or more individuals who shall include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in questions. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The members of the Expedited Complaint Review Committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

9. The Plan prepares a summary of the issues presented and decisions made which are maintained as part of the Expedited Grievance record.

10. The Plan issues the decision resulting from the Expedited Review in person or by phone to the Member and other appropriate parties within forty-eight (48) hours of receiving the Health Care Provider’s certification or seventy-two (72) hours of receiving the Member’s request for an Expedited Review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. In addition, The Plan mails written notice of the decision to the Member and other appropriate parties within two (2) business days of the decision using the template specified by DHS.

11. The Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, may file a request for an Expedited External Grievance Review with The Plan within two (2) business days from the date the Member, Member representative, and/or Health Care Provider, if the Health Care Provider filed the Grievance with consent, receives The Plan’s Expedited Grievance Decision. The Plan follows Department of Health guidelines when handling requests for expedited external Grievance Reviews.

12. The Member or Member representative may file a request for a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the Expedited Grievance Decision.
DHS Fair Hearing

1. A DHS Fair Hearing is a hearing conducted by DHS, Bureau of Hearings and Appeals or its designee.

2. A Member must file a Complaint or Grievance with The Plan and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If The Plan fails to provide written notice of a Complaint or Grievance decision within each processes’ required time frames, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

3. Members or Member representatives may request a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on the initial written notice of decision or within one hundred and twenty (120) days from the mail date on the written notice of The Plan’s Complaint decision or Grievance decision for any of the following:
   a. the denial, in whole or part, of payment for a requested service/item if based on lack of medical necessity;
   b. the denial or a requested service/item on the basis that the service or item is not a covered benefit;
   c. the denial or issuance of a limited authorization of a requested service/item, including the type or level of service/item;
   d. the reduction, suspension, or termination of a previously authorized service/item;
   e. the denial of a requested service/item but approval of an alternative service/item;
   f. the failure to provide services/items in a timely manner, as defined by the DHS;
   g. the failure of The Plan to decide a Complaint or Grievance within the required time frames;
   h. The Plan denies payment after a service(s)/item(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the MA Program; or
   i. The Plan denies payment after a service(s)/item(s) has been delivered because the service(s)/item(s) provided is not a covered benefit for the Member.
   j. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

2. The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request, unless The Plan failed to provide written notice of the Complaint or Grievance decision within the time frames required for each process. A Fair Hearing may be requested as follows:

   Fax: 1-717-772-6328
   Mail: Department of Human Services
       OMAP – HealthChoices Program
       Complaint, Grievance and Fair Hearings
       P.O. Box 2675
       Harrisburg, Pennsylvania 17105-2675

3. A Member who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for a DHS Fair Hearing is hand delivered, faxed, emailed, or post-marked within ten (10) days from the mail date on the Plan’s written notice of First Level Complaint or Grievance decision.
4. Upon receipt of the request for a DHS Fair Hearing, DHS’s Bureau of Hearings and Appeals or a designee will schedule a hearing. The Member and The Plan will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

5. The Plan is a party to the hearing and must be present. The Plan, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. DHS’s decision is based solely on the evidence presented at the hearing. The failure of The Plan to participate in hearing will not be reason to postpone the hearing.

6. The Plan will provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

7. If the Bureau of Hearings and Appeals has not taken final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, The Plan will follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Member (55 Pa. Code 275.4).

8. The Bureau of Hearings and Appeals adjudication is binding on The Plan unless reversed by the Secretary of DHS. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary’s final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on The Plan.

**Expedited Fair Hearing Process**

1. A request for an Expedited DHS Fair Hearing may be filed by the Member or Member’s representative, with proof of the Member’s written authorization for the representative to be involved and/or act on the Member’s behalf, with DHS either in writing or orally.

2. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

3. An Expedited DHS Fair Hearing will be conducted if a Member or a Member’s representative provides DHS with written certification from the Member’s Health Care Provider that the Member’s life, health, mental health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Member’s request for the Expedited DHS Fair Hearing is made orally. The certification must include the Health Care Provider’s signature. The Health Care Provider may also testify at the DHS Fair Hearing to explain why using the usual timeframes would place the Member’s health in jeopardy.

4. A Member who files a request for an Expedited DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for an Expedited DHS Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

5. Upon the receipt of the request for an Expedited DHS Fair Hearing, DHS’s Bureau of Hearings and Appeals or a designee will schedule a hearing.

6. The Plan is a party to the hearing and must participate in the hearing. The Plan, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of The Plan to participate in the hearing will not be reason to postpone the hearing.
7. The Plan will provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

8. The Bureau of Hearings and Appeals has three (3) business days from the receipt of the Member’s oral or written request for an Expedited Review to process final administrative action.

9. The Bureau of Hearings and Appeals adjudication is binding on The Plan unless reversed by the Secretary of DHS. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary’s final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on The Plan.

**Provision of and Payment for Service of Item Following the Decision**

If the Plan, Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, The Plan must authorize or provide the disputed service or item as expeditiously as the Member’s health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If The Plan requests reconsideration, The Plan must authorize or provide the disputed service or item pending reconsideration unless The Plan requests a stay of the Bureau of Hearings and Appeals decision and the stay is granted.

If the Plan, Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, The Plan must pay for the service or item that the Member received.

**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 The 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 foreign language interpreter services 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 allegations of fact or law 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
17. The Plan is flexible when scheduling the review to facilitate the Member's attendance. The Member is given at least seven (7) 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 Plan may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. In the scope of the attorney's representation of the committee, the attorney will not argue The Plan's position or represent The Plan or The Plan staff.

21. The committee may question the Member and the Member representative, the Health Care Provider and The Plan staff representing The Plan's position.

22. 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.

23. 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 the Health Care Provider has either failed to provide written Member consent or the written Member consent does not conform to applicable law regarding Grievances filed by Health Care Providers on behalf of Members (specific requirements are set forth below under Requirements for Grievances filed by Providers on Behalf of Members), the appeal will be processed through The Plan's Formal Provider Appeals Process. The Plan will notify the Health Care Provider in writing that the appeal will be processed through The Plan's Formal Provider Appeals Process because the requisite Member consent was not provided by the Health Care Provider and offer the Health Care Provider the opportunity to resubmit a Member consent that conforms to applicable law for Grievances filed by Health Care Providers on behalf of Members.
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 or in Appendix VI of the Provider Manual.

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 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 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.

**Recipient Restriction Subcommittee**
The Recipient Restriction Subcommittee is responsible for identifying, evaluating, monitoring, and tracking potential misutilization, fraud and abuse by Members.

**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.

**Southeast Behavioral Health/Physical Health MCO Pharmacy & Therapeutics Committee**
The Southeast Behavioral Health/Physical Health MCO Pharmacy & Therapeutics Committee reviews behavioral health medication policies and concerns and provides input to the Pharmacy and Therapeutics Subcommittee. This committee acts as a consultant to the Pharmacy and Therapeutics Subcommittee and meets quarterly.

**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 (CRN)
- Dentist (DDS and DMD) (including General Dentists and Pediatric Dentists)
- Medical Doctor (MD and DO)
- Occupational Therapist (OT)
- Oral Surgeon
- Physical Therapist (PT)
- Podiatrist (DPM)
- Speech and Language Therapist
- Therapeutic Optometrist
*Only private practices (practitioners who have an independent relationship with the Plan) require credentialing.

Locum tenens employed by a healthcare system or a hospital would be required to be credentialed by that organization or for that organization by another credible body. If the provider will be serving for a longer term, greater than 60 days, and credentialing is not delegated to the organization, or its surrogate, the Plan will credential those locum tenens identified by the organization.

The following criteria must be met as applicable, in order to evaluate a qualified Health Care 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 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 Provider is treating Members. The DEA certificate is non-transferrable by location.
- 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 Providers must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number with the application
- Board certification is required for all Providers who apply as a specialist.
- 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 Provider in the past 5 years
- A current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of $500,000/$1.5 million with excess coverage of $500,000/$1.5 million) – total coverage should equal $1 million/$3 million.
- Hospital admitting arrangements 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 Provider(s) who has admitting privileges at a participating hospital. Those Providers 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 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; and
• 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 providers to participate in CAQH or to submit applications. The Plan encourages all providers 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 (provider.credentialinghbg@amerihealthcaritaspa.com)

Paper Application Process
• Complete an application and attestation that includes 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

As part of the application process, the Plan will:
• Request information on Health Care Provider 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), System for Awards Management (SAM), Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS) 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 issues will be reviewed on a monthly basis at the Credentialing Committee meeting
• 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.
• 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.

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 information submitted to support their credentialing application, with the exception recommendations, and peer protected information obtained by the Plan. 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
• 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 calendar days from the date of the notification 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 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/AmeriHealth Caritas Northeast
ATTN: Credentialing Department
8040 Carlson Road, Suite 500
Harrisburg, PA 17112
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 is no accreditation status results, a current CMS State Survey will be accepted. If the Facility is not accredited and does not have a CMS State Survey, the Plan 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
  o Hospitals (acute care and acute rehabilitation)
  o Skilled Nursing Facilities (SNF)
  o Skilled Nursing Facilities providing sub-acute services
  o Nursing Homes
  o Sub-Acute Facilities
  o Home Health Agencies
  o Hospice
  o Ambulatory Surgical Center (ASC)
  o Durable Medical Equipment
  o Home Infusion
  o Dialysis Centers
  o Free Standing Sleep Centers/Sleep Labs
  o Free Standing Radiology Centers
  o Diabetic Education Programs
  o 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, 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
• 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.
  o 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), and System for Award Management (SAM)
• Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
• Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

After the submission of the application, Facilities:
• Have the right to review the information submitted to support their credentialing application, with the exception of recommendations, and peer protected information obtained by 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;
• 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/AmeriHealth Caritas Northeast
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-credentia ling and recertification.

**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 ongoing 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 or www.amerihealthcaritasnortheast.com→Providers→Communications→DHS/Medical Assistance Bulletins.

Resources:
Pennsylvania Medcheck 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: http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medichecklist/

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 Medcheck 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://www.sam.gov/portal/SAM/#1

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 Provider 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 its 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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com):

<table>
<thead>
<tr>
<th>Acute Pharyngitis in Children</th>
<th>Hemophilia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>HIV</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Immunizations and Screenings</td>
</tr>
<tr>
<td>Chronic and Obstructive Pulmonary Disease</td>
<td>Maternity</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Preventive Health Guidelines</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Sickle Cell</td>
</tr>
</tbody>
</table>
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 or AmeriHealth Caritas Northeast's Utilization Management Department at 1-888-498-0504
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within 5 business days of your request.

Please remember that the Plan has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. Call the Medical Director Hotline at: 1-888-209-3537.

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 or AmeriHealth Caritas Northeast's Utilization Management Department at 1-888-498-0504) is available for Providers and Members 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.

The Plan has realigned its Utilization Management department, which includes integration with Provider Network Management. We have formed Unified Interdisciplinary Teams (UNITS) with the ultimate goal of improving administrative processes, identifying and bridging gaps in patient care early.

Each UNIT is comprised of utilization managers, case managers, rapid response associates, physician reviewers, provider network account executives, behavioral health, pharmacy and claims associates works collaboratively with assigned facilities. Each UNIT team member brings diverse knowledge and skills that improve efficiency, response time, communication and ultimately patient care.

After business hours and on weekends and holidays, Health Care Providers and Members are instructed to contact the On-Call Nurse through AmeriHealth Caritas Pennsylvania's Member Services Department at 1-888-991-7200 or AmeriHealth Caritas Northeast's Member Services Department at 1-855-809-9200. 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 or Member, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse
is responsible to contact the requesting Health Care Provider or Member with the outcome of their 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.

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.

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>
<thead>
<tr>
<th>Case Type</th>
<th>Decision</th>
<th>Initial Notification</th>
<th>Written Confirmation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Precertification (including Home Health Care)</td>
<td>24 hours from receipt of request**</td>
<td>24 hours from receipt of request</td>
<td>24 hours from initial notification</td>
</tr>
<tr>
<td>Non-Urgent Precertification (excluding Home Health Care)</td>
<td>2 business days from receipt of the request **</td>
<td>2 business days from receipt of the request</td>
<td>2 business days from initial notification</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>24 hours from receipt of the request**</td>
<td>24 hours from receipt of the request</td>
<td>24 hours of the initial notification</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>30 calendar days from receipt of the records</td>
<td>30 calendar days from receipt of the records</td>
<td>The earlier of 15 business days or 30 calendar days from receipt of the records</td>
</tr>
<tr>
<td>Home Health Care Non-Urgent Pre-certification</td>
<td>48 hours from receipt of request**</td>
<td>48 hours from receipt of request</td>
<td>48 hours from initial notification</td>
</tr>
</tbody>
</table>

* 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).

**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. The Plan will not retroactively deny reimbursement for a covered service provided to an eligible Member by a Health Care Provider who relied on written or oral authorization from the Plan or an agent of the Plan, unless there was material misrepresentation or fraud in obtaining the authorization. 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:
- At any time while the Member is an inpatient
- Up to 2 business days after the Member’s discharge date, whichever is later
- Up to 2 business days after a determination for a Prior (Pre-Service) request has been rendered
- Up to 2 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 1-888-209-3536. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal. For information on the types of issues that may be the subject of a Formal Provider Appeal, please see Section VII.

**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 six languages for Members with Limited English Proficiency. Letters are translated into other languages 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 Needs and Case Management
Integrated Health Care Management (IHCM)
The Case Management program is a population-based health management program that utilizes a blended model that provides comprehensive case management and disease management services 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. The CM/CC 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 the CM/CC Program include, but are not limited to:

- Multiple diagnoses (3 or more major diagnoses)
- Pregnancy
- Pediatric Members requiring assistance with EPSDT services
- Pediatric Members requiring in-home nursing 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 Need
- Members with Chronic Diseases including:
  - Heart Failure
  - Diabetes
  - Asthma
  - COPD
  - Coronary Artery Disease
  - Sickle Cell
  - HIV
  - Hemophilia

The primary method of service for the CM/CC Program is telephonic outreach, assessment, and intervention. The CM/CC staff makes outreach calls to the Member, and/or Member representative, as indicated, and collaborates with the PCP and Specialist to develop a treatment plan. For more information requests and/or to refer Members to the CM/CC Program call:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>1-877-693-8271, option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-5966</td>
</tr>
</tbody>
</table>

Disease Management (DM)
Members identified as high-risk receive targeted education and fact sheets on their disease as well as engagement into our Complex Case Management program. Care managers address goals, and develop a plan of care with input from the member and the physician(s). Members assessed to be low-risk receive information via mailings with access to a case manager as necessary.

Special Needs Unit
The Special Needs Unit provides coordination of services to new and existing adult and pediatric Plan Members to the plan and existing Members with short-term and/or intermittent needs who have single problem issues and/or multiple co-morbidities. The case managers in this unit support Members in resolution of pharmacy, DME and/or dental access issues, assistance with transportation, identification of and access to Specialists, or referral and coordination with behavioral health providers or other community resources. There is also a dedicated case 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 Needs.

For more information requests and/or to refer Members to the Special Needs Unit call:

| AmeriHealth Caritas Pennsylvania | 1-800-684-5503 |
| AmeriHealth Caritas Northeast | 1-888-498-0766 |

Pediatric Shift Care
Pediatric Shift Care Management is provided to members less than 21 years of age who are medically fragile and have chronic health care needs and receive skilled nursing and/or home health aide services.

For more information and/or to refer Members to the Pediatric Shift Care Management program call:

| AmeriHealth Caritas Pennsylvania Pediatric Shift Care | 1-800-521-6622 |
| AmeriHealth Caritas Northeast Pediatric Shift Care | 1-888-498-0504 |

Urgent Response Team
The Urgent Response Care Management team provides coordination of services to Pediatric and Adult members who have an “urgent” need. The members may have a single issue or a variety of issues that need to be addressed urgently/immediately. The care managers in this unit support Members in resolution of pharmacy, DME, dental access issues, and coordination of behavioral health and community resources that need to be addressed urgently/immediately.

For more information, requests and/or refer Members to the Urgent Response Team call:

| AmeriHealth Caritas Pennsylvania | 1-800-684-5503 |
| AmeriHealth Caritas Northeast | 1-855-859-4110 |

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 using communication and available resources to promote quality and cost effective outcomes. The design of the Bright Start Maternity Program allows for collaboration between the Care Manager, the 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. The Plan developed this comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population.

Program Goals:

- Early identification of pregnant Members (utilizing laboratory and pharmacy data) and accurate contact information
- Improve health outcomes for neonates
- Facilitate access to needed services and resources
  - Dental Screenings
  - Behavioral Health Screenings
- Build collaborative relationships with community-based agencies that specialize in services for maternal-child health
- Encourage early prenatal care and continuum of care through post-partum period by increasing awareness through member newsletters, media engagements, provider education and community alliances
- Assess and address healthcare disparities in pregnant women

Members enrolled in the Bright Start Maternity Program receive a variety of interventions depending upon the assessed risk of their pregnancy. Case Managers play a hands-on role, as necessary, in coordinating and facilitating care with the members’ physicians and home health care agencies. They also outreach to ensure member follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

Members are triaged using informatics reports and assessment information provided by the obstetrics practitioner into low-risk and high-risk populations.

- Low-risk Members receive educational material about pregnancy, preparing for delivery, and how to access a Plan Case Manager for any questions/issues.
- Low-risk Members also receive an outreach call after delivery to complete a post-partum survey.
- Members that are triaged as high-risk receive “high touch” case management interventions by a case manager.

Bright Start Maternity programs designed to positively impact birth outcomes:

- Moms 2B program
- Text4 Baby program
- Breast Pump program
- Postpartum visit coordination
- Postpartum care 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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com).

To refer Members to the Bright Start Maternity Program call:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania</th>
<th>1-877-364-6797</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast</td>
<td>1-888-208-9528</td>
</tr>
</tbody>
</table>
**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 ensure the Member receives the appropriate clinical assessment, education and support for a healthy transition from the hospital to home.

All Members and newborns receive a clinical nursing visit within one (1) week of discharge from the hospital.

- All deliveries (vaginal or caesarian) are eligible for up to two (2) home visits.
- If complications are identified during the home visit, it is the responsibility of the Home Visit Provider to request the authorization of additional home visits or other services.
- When a detained baby is discharged more than one (1) week from birth, an authorization is required to receive a home visit.

**Home Nursing Visit**
The Postpartum Home Visit includes a physical, psychosocial and environmental assessment with individualized education, counseling and support.

- Visit timeframes:
  - First visit – day 1-21
  - Second visit – day 21-56

**Requesting a Postpartum Home Visit**
Network Providers should contact their facility's Discharge Planner to request a Postpartum Home Visit for their patient.

**Pediatric Preventive Health Care Program – Known as 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 Section II Referral and Authorization Requirements and Policies.
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 Public Affairs and Marketing team targets Plan members who are non-compliant for HEDIS measures, in an effort to facilitate health screenings, provide education, close care gaps, and re-connect them with their PCP’s. The Plan’s Public Affairs & Marketing team works in collaboration with the Rapid Response Outreach Team and Case Management units to achieve these desired outcomes.

Rapid Response and Outreach Team (RROT)

The Rapid Response Team was created to address the urgent non-clinical needs of our Members. The RROT is trained to assist in the rapid triage of the Member’s needs. Their goal is to reduce both unnecessary emergency room visits and in-patient stays as well as assist in removing barriers to needed health care services.

The team consists of registered nurses, social workers and care connectors (non-clinical) who are trained to triage and assist members in overcoming barriers in achieving their health care goals. The RROT can assist members:

- Schedule doctor appointments.
- Help with transportation concerns.
- Help members understand health conditions.
- 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 Care Coordination line. Referrals to RROT are also received through many sources, such as the Special Needs Call Line, Member Services, Pharmacy, Utilization Review, Retention Unit and Provider Relations. The RROT toll-free number is provided as a contact point for all member mailings and automated messaging – encouraging members who need additional support or information to call.

<table>
<thead>
<tr>
<th>Rapid Response</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania Rapid Response</td>
<td>1-800-684-5503</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast Rapid Response</td>
<td>1-855-859-4110</td>
</tr>
</tbody>
</table>

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 and require further assistance from Care Management staff.

3. **Clinical and Non-Clinical Case 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 Health Care Management (IHCM) 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, and much more.

There are two ways to alert the Let Us Know Program:

1. Contact the AmeriHealth Caritas Pennsylvania Rapid Response Unit at 1-800-684-5503 or the AmeriHealth Caritas Northeast Rapid Response Unit at 1-855-859-4110 from 8:00 a.m. until 6:30 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](http://www.amerihealthcaritaspa.com) or the AmeriHealth Caritas Northeast Provider Center at [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com).

2. Refer a patient to the AmeriHealth Caritas Pennsylvania Integrated Health Care Management Program (IHCM) at **1-877-693-8271, option 2**, or the AmeriHealth Caritas Northeast Integrated Care Management Department at **1-888-208-5966**.

**Tobacco Cessation**
The tobacco cessation program offers Members a series of educational classes easily accessible within their communities. The program offers targeted outreach to Members who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these Members to enroll in tobacco cessation classes. For more information go to the Department of Health website: [http://www.portal.state.pa.us/portal/server.pt/community/smoke_free/14315/pre-approved_tobacco_cession_registry/557673](http://www.portal.state.pa.us/portal/server.pt/community/smoke_free/14315/pre-approved_tobacco_cession_registry/557673)

**Breast Cancer Screening and Outreach Program (BCSOP)**
BCSOP is an outreach program developed to increase Members’ awareness of the importance of a mammography screening and to encourage female Members age 50 and older to have regularly scheduled mammograms. The Plan establishes partnerships with community organizations. Designated outreach staff contacts Members by phone or mail, to schedule mammography screenings, remind Plan Members of appointments, and reschedule appointments if necessary. At the time of the screening, Members are educated about breast self-exam and instructed to contact their doctor for the results of the screening. All results are sent to the PCP for follow-up.
Domestic Violence Intervention

The Plan is participating in a collaborative domestic violence education program with the Department of Human Services (DHS) and other HealthChoices Managed Care Organizations. There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health Care Providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables Health Care Providers to assist their patients, and family 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.

- **Routine**ly 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](http://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 languages.

For a list of where to get help for a patient, please see the Appendix.

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 Integrated Health Care Management Program (IHCM) department at:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania IHCM Program</td>
<td>1-877-693-8271, option 2</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast IHCM Program</td>
<td>1-888-208-5966</td>
</tr>
</tbody>
</table>

with questions about any of the health education programs or 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


What children are eligible?
Children from birth to age 5 who have special 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.

**Specialists as PCPs for Special Needs Members**

Specialists may be able to serve as PCPs for Special Needs Members, including Members that have a disease or condition that is life threatening, degenerative, or disabling. Plan Members may contact the Special Needs Unit to request designation as a "Special Needs Member" and request approval to utilize a specialist as PCP. Case 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 Special Needs Unit 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 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.
Section 10: Member Rights and Responsibilities
**Member Rights & Responsibilities**

The Plan is committed to treating our Members with respect. The Plan, its Network Providers, and other Providers of service, may not discriminate against Members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law.

**Member Rights**

Members have the right 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.
- Be treated with dignity and respect by health care providers and the Plan.
- Get materials and/or help in languages and formats other than written English, such as Braille, Audio or Sign language, if necessary.
- Have their personal and health information and medical records kept private and confidential.
- Expect that the Plan will give them our Notice of Privacy Practices without requesting it. They have the right to:
  - Approve or deny the release of identifiable medical or personal information, except when the release is required by law.
  - Ask for a list of disclosures of protected health information.
  - Ask for and receive a copy of their medical records as allowed by applicable federal and state laws.
  - Ask that the plan change certain protected health information.
  - Ask that any message with protected health information from the Plan be sent to them by alternate means or to an alternate address or phone number.
- Talk with their health care provider about:
  - Their treatment plans.
  - The kinds of care they can choose to meet their medical needs in a way they understand.
  - Their treatment plans regardless of cost or benefit coverage.
- 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 the Department of Human Services.
- Voice complaints about and/or appeal decisions made by the plan and its health care providers.
- File for a Fair Hearing with the Department of Human Services.
- Make an advance directive.
- Be given an opportunity to make suggestions for changes in Plan policies and procedures.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

**Member Responsibilities**

Members have the responsibility to inform the Plan and its Network Providers of any changes in eligibility, or any other information that may affect their membership, health care needs or access to benefits. Some examples include, but are not limited to the following:

- Pregnancy
- Birth of a baby
- Change in address or phone number
- A Member or a Member's child is covered by another health plan
- Change in PCP
- Special medical concerns
- Change in family size, or
- Move out of the county or state.

Members have the responsibility to cooperate with the Plan and its Network Providers. This includes:
- Following Network Provider instructions regarding care
- Making appointments with their PCP
- Canceling appointments when they cannot attend
- Calling the Plan when they have questions
- Keeping their benefits up to date with the County Assistance Office case worker. Finding out when their benefits will end and making sure that all demographic information is up to date to keep their benefits.
- Understanding their health problems and working with their provider to set goals for their treatment, 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 Advance Directives, They should go to [http://tinyurl.com/patient-self-determination](http://tinyurl.com/patient-self-determination) or call 717-558-7750.
Section 11: Regulatory Provisions
Access to & Financial Responsibility for Services

Member’s Financial Responsibilities

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.

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.

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. This applies to non-participating out-of-state providers as well.
Additionally, all providers, including those who order, refer or prescribe items or services for The Plan’s members, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the Plan’s Provider website at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.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: http://provider.enrollment.dpw.state.pa.us/

**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 II of the Manual titled "Referral and Authorization Requirements" for this information. Members should also be referred to the Member Handbook for a complete 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 I of the Manual titled "Benefit Limit and Co-Payment Schedule" or call AmeriHealth Caritas Pennsylvania’s Provider Services Department at 1-800-521-6007 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370 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 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200 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 VI 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) outlining all requirements can be accessed on the Plan’s Provider website at www.amerihealthcaritaspa.com or www.amerihealthcaritasnortheast.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.

April 14, 2003 was the date of required compliance with the provisions stipulated in the HIPAA Privacy Regulations. In order to ensure compliance with these regulations, the Plan took several measures to ensure such compliance, 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
- Issued 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 Case 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 or the AmeriHealth Caritas Northeast Provider Center at www.amerihealthcaritasnortheast.com and click on the HIPAA Page or contact AmeriHealth Caritas Pennsylvania’s Provider Services Department at 1-800-521-6007 or AmeriHealth Caritas Northeast’s Provider Services Department at 1-888-208-7370.

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 Northeast’s Provider Services Department at 1-888-208-7370 or AmeriHealth Caritas Pennsylvania’s Member Services Department at 1-888-991-7200 or AmeriHealth Caritas Northeast’s Member Services Department at 1-855-809-9200.

AmeriHealth Caritas Pennsylvania
Cultural Competency

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.

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.

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 are mandated to provide 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 other languages 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 limited or low English proficiency, 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 cultural 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 other languages 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 translation 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
  - Burmese
  - Chinese (simplified/Mandarin)
  - Portuguese (Brazil)
  - Korean
  - Arabic
  - Cambodian (Khmer)
  - Gujarati
  - Nepali
  - Bengali
  - Vietnamese
  - French
  - Haitian Creole
  - Albanian

For complete details and guidelines refer to PA DHS MA Bulletin 99-17-11 on the Provider Center at [www.amerihealthcaritaspa.com](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com) → Providers → Communications → DHS/Medical Assistance Bulletins.

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](http://www.amerihealthcaritaspa.com) or [www.amerihealthcaritasnortheast.com](http://www.amerihealthcaritasnortheast.com).

Or contact Provider Services at:

<table>
<thead>
<tr>
<th>AmeriHealth Caritas Pennsylvania Provider Services</th>
<th>1-800-521-6007</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Northeast Provider Services</td>
<td>1-888-208-7370</td>
</tr>
</tbody>
</table>

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.

The Plan has a Cultural Competency Plan. Providers may request a copy by contacting Provider Services:

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth Caritas Pennsylvania Provider Services</td>
<td>1-800-521-6007</td>
</tr>
<tr>
<td>AmeriHealth Caritas Northeast Provider Services</td>
<td>1-888-208-7370</td>
</tr>
</tbody>
</table>

**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
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.

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.
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**

Sec.  
1101.11. General provisions.

**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.  
1101.42b. 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**

1101.61. Reimbursement policies.  
1101.62. Maximum fees.  
1101.63. Payment in full.  
1101.63a. Full reimbursement for covered services rendered—statement of policy.  
1101.64. Third-party medical resources (TPR).  
1101.65. Method of payment.  
1101.66. Payment for rendered, prescribed or ordered services.  
1101.67. Prior authorization.  
1101.68. Invoicing for services.  
1101.69. Overpayment—underpayment.  
1101.69a. Establishment of a uniform period for the recoupment of overpayments from Providers (COBRA).  
1101.70. [Reserved].  
1101.71. Utilization control.  
1101.72. Invoice adjustment.
1101.73. Provider misutilization and abuse.
1101.74. Provider fraud.
1101.75. Provider prohibited acts.
1101.75a. Business arrangements between nursing facilities and pharmacy Providers—statement of policy.
1101.76. Criminal penalties.
1101.77. Enforcement actions by the Department.
1101.77a. Termination for convenience and best interests of the Department—statement of policy.

ADMINISTRATIVE PROCEDURES

1101.81. [Reserved].
1101.82. Reenrollment.
1101.83. Restitution and repayment.
1101.84. Provider right of appeal.

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/partIIltoc.html

Links are to:
Reporting Communicable and Incommunicable Diseases (Chapter 27)
MA Program Payment Policies (Chapter 1150)
Ambulance Transportation (Chapter 1245)
Ambulatory Surgical Center Services and Hospital Short Procedure Unit Services (Chapter 1126)
Birth Center Services (Chapter 1127)
Certified Registered Nurse Practitioner Services (Chapter 1144)
Chiropractors’ Services (Chapter 1145)
Clinic and Emergency Room Services (Chapter 1221)
Dentists’ Services (Chapter 1149)
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)
Section 13: Appendix
Forms and Information:

1. Hospital Notification of Emergency Admission form
2. Obstetrical Needs Assessment Form (ONAF)
3. DHS MA-112 Newborn form
4. J&B Medical Supply Incontinence Supply Prescription form
5. Listing of Reference and Outpatient Laboratories
6. EPSDT Physician's Desk Guide
7. EPSDT Dental Referral Notification form
8. PA EPSDT Periodicity Schedule and Coding Matrix
9. CDC Recommended Childhood Immunization and Catch-up Schedule
10. Requirements and Resources for Structured Screening and Developmental Delays and Autism Spectrum Disorder
12. Observation Billing Guidelines
13. CMS Hospital Acquired Conditions
14. MA Bulletin 99-10-14 Missed Appointments
15. Provider Reference Guide
16. Non-Participating Provider Emergency Services Payment Guidelines
17. Provider Change form
18. Procedures reimbursed above capitation
19. Claims Appeals spreadsheets
20. Enrollee Consent Form for Physicians Filing a Grievance on behalf of a Member.
21. Domestic Violence – Resources for Patients
22. Claims Filing Instructions
23. Sterilization Consent form (MA31)
24. The Patient Acknowledgement for Hysterectomy (MA 30)
25. Physician Certification for Abortion (MA3)
26. Recipient Statement form (MA368 and MA369)
27. Provider Claim Refund form