4 Health Partners Provider Manual
Health Partners Benefit Summary

Purpose: This chapter provides an overview of the benefits available to Health Partners members.

Topics:

- Summary of Benefits.

Module Contents

Figures

Overview

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

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

Summary of Benefits

The following chart is a quick reference that lists many Health Partners benefits and services. It indicates whether a PCP referral is required, and summarizes important guidelines. Additional information about covered and non-covered services follows this chart.

Prior authorization is ALWAYS REQUIRED for out-of-network services, except emergency/urgent care.

Note: *Generally, DME services or items that are under $500 per claim line and with specific HCPCS coding (NOT Code E1399) do not need prior authorization. Please see the end of this section for detailed information.*

Health Partners Medicaid Benefits

The following table lists the benefits available to Health Partners members and any PCP referral and/or prior authorization requirements associated with those services.

Table 1: Health Partners Benefits

Benefit/Service	PCP Referral	Prior Authorization
Acupuncture	No	No
AIDS Waiver Service	No	No
Ambulance (Non-Emergent): Nonpar or >$500	No	Yes
Ambulatory Surgery Center/ Short Procedure Unit	No	No (except dental services)
Anesthesia	No	No
Assistant Surgeon	No	No
Audiology Services	Yes	No
Comprehensive Dental Services	No	No Dental service must meet medical necessity criteria to be covered.
Behavioral Specialist Consultant	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Blood/Blood Product	Yes (Outpatient)	Yes (In-Home or IP setting)
Burial	Not covered	
Case Management/MH/MR	No	No

Table 1: Health Partners Benefits

Benefit/Service	PCP Referral	Prior Authorization
Cleft Palate	Yes	Yes (surgery)
Crowns, Dentures	No	Yes
Diagnostic Radiology	Yes	Yes (MRI, CT, PET)
PET Scan	Yes	Yes
Drug & Alcohol Outpatient Services	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Durable Medical Equipment Purchase > $500	No	Yes (prescription and letter of medical necessity)
Durable Medical Equipment Rental	No	Yes (prescription and letter of medical necessity)
EPSDT Screening (excludes treatment)	No	No
EPSDT Services	No	No
Family Based Therapy	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Family Planning	No	No
Healthy Beginnings Plus (HB+)	No	No
Home Health Care	No	Yes (letter of medical necessity)
Hospice	No	Yes (letter of medical necessity)
Intermediate Care Facility, Intermediate Care Facility/Mental Retardation, Ombudsman Resource Center	No	Yes (HP responsible for physical health only)
Inpatient Hospital	Yes	Yes (for elective medical services)
Laboratory	Yes	No (must use capitated lab)

Table 1: Health Partners Benefits

Benefit/Service	PCP Referral	Prior Authorization
Medical Diagnostics	Yes	No
Medical/Surgical Supplies >$500	No	Yes (prescription and letter of medical necessity)
Methadone Maintenance	Covered by Behavioral Health Managed Care Organization (BHMCO)	Yes (pregnant members only)
Mobile Therapy	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Non-Emergent Transportation	No	Yes
Nuclear Medicine - BC, PC	Yes	No
Nursing Care (County/ Private Nursing Facilities)	Yes	Yes
Obstetrical - Outpatient	No	No
Oral Surgery	No	Yes
Orthodontic	No	Yes
Orthotic > $500	No	Yes
Pediatric Services - Outpatient	No	No
Periodontal Services	No	Yes
Pharmaceutical	Prescription	Yes (if not on formulary or designated as subject to prior auth)
Physical/Occupational/ Speech Therapy - In Home	No	Yes
Physical/Occupational/ Speech Therapy - Inpatient (non-rehab)	No	Yes

Table 1: Health Partners Benefits

Benefit/Service	PCP Referral	Prior Authorization
Physical/Occupational/ Speech Therapy - Inpatient (rehab unit/ facility)	No	Yes
Physical/Occupational/ Speech Therapy - Outpatient	No	Yes
Prosthetic Device > $500	No	Yes (prescription and letter of medical necessity)
Prosthodontic Professional	No	No (must meet basic medical necessity criteria)
Psychiatric	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Psychiatric Partial Hospitalization	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Radiation Therapy	Yes	No
Renal Dialysis	No	No
Sign Language Interpretation	No	No
Specially Adapted DME	No	Yes (prescription and letter of medical necessity)
Summer Therapeutic Activities Program	Covered by Behavioral Health Managed Care Organization (BHMCO)	
Elective Inpatient Surgical Care	Yes	Yes

HP Benefits During and After Pregnancy

Limitations on the number of services or applicability of copayments on General Assistance and Medical Assistance do not affect pregnant members who are confirmed to be pregnant. Members are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy and until 60 days post-partum. These services include expanded nutritional counseling and smoking cessation services. However, services not ordinarily covered under a pregnant member's HCBP package are also not covered, even while pregnant.

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

To ensure that a claim be processed without a service limitation, providers must bill with a pregnancy indicator on the claim. These indicators include:

CMS-1500	Visit code **09** in box 24H
UB04/CMS 1450	Field locator 24-30 Condition code **B3**
837-I	2300 Loop, H1, 01, qualifier **BG** Condition code **B3**
837-P	Loop 2000 B, Segment PAT, PAT **09**, Data Element **Y**
NCPDP	Value of **2** in Pregnancy Indicator field.

Pregnant members have no service limitations (i.e. limits on the number of services or responsibility for copays) during their pregnancy and 60 days post-partum. After this period the member is moved to her regularly assigned benefit package and may then have service restrictions and copayments.

Benefit Grids

The following section provides an overview of the benefit packages available to Health Partners members.

Table 2: Health Choices Benefit Packages 1,2 and 4

DPW/EVS Package	HCBP 1	HCBP 2	HCBP 4
Package Description	Children 0-20 Years of Age	Medical Assistance Adults (age 21+) Categorically Needy ➢ Temporary Aid to Needy Families ➢ Healthy Horizons - Without Medicare ➢ SSI - Without Medicare ➢ Federal General Assistance ➢ Healthy Beginnings (Pregnant Women)	Medical Assistance Adults (age 21+) Medically Needy ➢ Temporary Aid to Needy Families ➢ SSI - Without Medicare ➢ Federal General Assistance
Service Copayments	➢ No Copays for children 0-20 years of age ➢ Pregnant Women are exempt	➢ MA copays apply ➢ Pregnant women are exempt	➢ MA copays apply ➢ Pregnant women are exempt

Table 2: Health Choices Benefit Packages 1,2 and 4

DPW/EVS Package	HCBP 1	HCBP 2	HCBP 4
Rx Copay-ments & Limits	➢ No prescription limits apply ➢ No prescription copays apply for 0-17 years of age ➢ Ages 18-20, prescription copays apply ➢ Pregnant members are exempt ➢ Except those who qualify for MA under Title IV-B Foster Care or Title IV-E Foster Care and Adoption Assistance. ➢ Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	➢ MA Prescription copays apply ➢ The following types of drugs are exempt from copays ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles ➢ Pregnant women are exempt ➢ Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	MA Prescription copays apply The following types of drugs are exempt from copays ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles ➢ Pregnant women are exempt ➢ Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.

Table 2: Health Choices Benefit Packages 1,2 and 4

DPW/EVS Package	HCBP 1	HCBP 2	HCBP 4
Inpatient Limits	None	No limit on Acute Care admissions. 1 Rehab admission per benefit year (includes related physician services) Pregnant women are exempt	No limit on Acute Care admissions. 1 Rehab admission per benefit year (includes related physician services). Pregnant women are exempt
Other Restrictions (applicable to all members, including pregnant women)	Comprehensive Outpatient Rehab Facility (CORF) Medicare deductible and coinsurance only. Certified Registered Nurse Anesthetist , Medicare deductible and coinsurance only. Respite Care Medicare deductible and coinsurance only	Corrective vision equipment/supplies only covered if related to cataract or aphakia treatment. Comprehensive Outpatient Rehab Facility (CORF), not covered. Certified Registered Nurse Anesthetist, not covered. Respite Care, not covered. Residential Treatment Facilities, not covered.	Dental services only covered if authorized for inpatient, ambulatory surgical center or a short procedure unit due to medical necessity. Birth control drugs and legend drugs provided in a Long Term Care facility are the only pharmaceuticals covered. Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Durable Medical Equipment and Medical Supplies only covered is used for family planning or for home health services.

Under Medical Assistance coverage, if Members in benefit category **HCBP 1** also have Medicare as the primary insurer, the Medicare deductible and coinsurance for the following services will be considered by Health Partners and are payable up to the amount that would be payable if Medical Assistance were primary.

- Comprehensive Outpatient Rehab Facility (CORF)
- Physical Therapist
- Certified Registered Nurse Anesthetist
- Respite Care

- Residential Treatment Facilities

Table 3: Health Choices Benefit Packages 3, 5 and 8

DPW/EVS Package	HCBP 3	HCBP 5	HCBP 8
Package Description	General Assistance Adults (age 21+) Categorically Needy General Assistance - Categorically Needy Federal General Assistance	General Assistance Adults (age 21+) Medically Needy Federal General Assistance	Categorically Needy (age 21+) with Medicare Healthy Horizons - with Medicare SSI - with Medicare
Service Copayments	GA copays apply Pregnant women are exempt	GA copays apply (inhaled asthma drugs exempted) Pregnant women are exempt	Medicare is Primary for these Members

Table 3: Health Choices Benefit Packages 3, 5 and 8

DPW/EVS Package	HCBP 3	HCBP 5	HCBP 8
Rx Copayments & Limits	GA copays apply (inhaled asthma drugs exempted) Six (6) prescriptions refills per month, except if the drugs are classified as one of: ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles Pregnant women are exempt from limits and copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	GA copays apply (inhaled asthma drugs exempted) Six (6) prescriptions refills per month, except if the drugs are classified as one of: ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles Pregnant women are exempt from limits and copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	MA copays apply No prescription limits The following types of drugs are exempt from copays ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles Pregnant women are exempt from copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.

Table 3: Health Choices Benefit Packages 3, 5 and 8

DPW/EVS Package	HCBP 3	HCBP 5	HCBP 8
Inpatient Limits	No limit on Acute Care admissions One (1) Rehab Hospitalization per benefit year (includes related physician services) Pregnant women are exempt from these limits.	No limit on Acute Care admissions One (1) Rehab Hospitalization per benefit year (includes related physician services) Pregnant women are exempt from these limits.	Medicare is Primary for these Members.
Other Restrictions (applicable to all members, including pregnant women)	Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Durable Medical Equipment and Medical Supplies only covered if used for family planning or for home health services. Renal Dialysis Center services are not covered. Comprehensive Outpatient Rehab Facility (CORF), not covered. Certified Registered Nurse Anesthetist, not covered. Respite Care, not covered Residential Treatment Facilities, not covered. Nutritionist not covered.	Dental services only covered if authorized for inpatient, ambulatory surgical center or a short procedure unit due to medical necessity. Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Durable Medical Equipment and Medical Supplies only covered if used for family planning or for home health services. Renal Dialysis Center services are not covered. Comprehensive Outpatient Rehab Facility (CORF), not covered. Certified Registered Nurse Anesthetist, not covered. Respite Care, not covered. Residential Treatment Facilities, not covered. Nutritionist not covered.	Birthing Centers are covered. Corrective vision equipment/supplies only covered if related to cataract or aphakia treatment. Nutritionist, not covered. Only Medicare coinsurance and deductible is covered for: ■ Comprehensive Outpatient Rehab Facility (CORF) ■ Physical Therapy ■ Certified Registered Nurse Anesthetist (CRNA)

Table 4: Health Choices Benefit Plans 10, 13 and 14

DPW/EVS Package	HCBP 10	HCBP 13	HCBP 14
Package Description	Medically Needy with Medicare Specified Low-Income Medicare Beneficiaries (SLMB)	Medically Needy with Medicare Qualified Medicare Beneficiaries (QMB)	Caregorically Needy with Medicare Specified Low-Income Medicare Beneficiaries (SLMB)
Service Copayments	For these Members, Medicare is Primary.	For these Members, Medicare is Primary	For these Members, Medicare is Primary

Table 4: Health Choices Benefit Plans 10, 13 and 14

DPW/EVS Package	HCBP 10	HCBP 13	HCBP 14
Rx Copayments & Limits	MA copays apply The following types of drugs are exempt from copays: ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles ➢ No prescription limits Pregnant women are exempt from limits and copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	GA copays apply (inhaled asthma drugs exempted) Six (6) prescriptions refills per month, except if the drugs are classified as one of: ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles Pregnant women are exempt from limits and copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.	MA copays apply No prescription limits The following types of drugs are exempt from copays ➢ AIDS Drugs ➢ Anti-anxiety ➢ Anti-convulsants ➢ Anti-depressants ➢ Anti-diabetics ➢ Anti-glaucoma drugs ➢ Anti-hypertensives ➢ Anti-manic ➢ Anti-neoplasties ➢ Anti-Parkinson drugs ➢ Anti-psychotics ➢ Asthma (inhaled) drugs ➢ Cardiovascular preparations ➢ Oral contraceptives ➢ Test strips, lancets, meters and needles Pregnant women are exempt from limits and copayments. Copays do not apply to members who are in a long term care facility or other medical instutions such as an Intermediate Care Facility for Mental Retardation.

Table 4: Health Choices Benefit Plans 10, 13 and 14

DPW/EVS Package	HCBP 10	HCBP 13	HCBP 14
Inpatient Limits	For these Members, Medicare is Primary.	For these Members, Medicare is Primary	For these Members, Medicare is Primary
Other Restrictions (applicable to all members, including pregnant women)	Dental Services only covered for inpatient, ambulatory surgical center or a short procedure unit due to medical necessity and only for Medicare coinsurance and deductible. Birth control drugs and legend drugs provided in a Long Term Care facility are the only pharmaceuticals covered and only for Medicare coinsurance and deductible. Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Medical Supplies only covered if used for family planning or for home health covered services and only for Medicare coinsurance and deductible. Birth Centers are covered. Nutritionist, not covered. Only Medicare coinsurance and deductible is covered for all other services.	Dental services only covered if authorized for inpatient, ambulatory surgical center or a short procedure unit due to medical necessity. Pharmaceuticals coverage limited to barbiturates, benzodiazepines, legend birth control drugs and certain over the counter drugs. Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Durable Medical Equipment and Medical Supplies only covered if used for family planning or for home health covered services. Nutritionist not covered. Only Medicare coinsurance and deductible is covered for: ➢ Comprehensive Outpatient Rehab Facility (CORF) ➢ Physical Therapy ➢ Certified Registered Nurse Anesthetist (CRNA) ➢ Respite Care ➢ Certified Rehabilitation Agency	Corrective vision equipment/ supplies only covered if related to cataract or aphakia treatment. Nutritionist, not covered. Only Medicare coinsurance and deductible is covered for: ➢ Comprehensive Outpatient Rehab Facility (CORF) ➢ Physical Therapy ➢ Certified Registered Nurse Anesthetist (CRNA) ➢ Certified Rehabilitation Agency ➢ Respite Care

For members with benefit packages **HCBP 8**, **10**, **13**, or **14**, if Medicare is the primary insurer and Medicaid is secondary, no benefit limits apply. If Medicare denies a service or claim and the Medicaid limits below have been reached, the service will be denied. For example, if a member has had 1 Inpatient rehab admission Medicare denies the second inpatient rehab admission. Since that rehab admission exceeds the 1 per year Medicaid limit, Health Partners will deny the claim. If Medicare pays the 2nd admission, Health Partners will pay the co-insurance or deductible up to the amount Health Partners would have paid had Health Partners been primary.

Copays for Medicaid Members

Medicaid members age 18 and over and in the General Assistance and Medical Assistance categories will have to pay a copay for prescriptions and various medical services*. This information is distributed to members through their Member Handbooks and on Health Partners' website, *http://www.healthpart.com*. It is reprinted here for your reference.

SERVICE	MA COPAYMENT	GA COPAYMENT
Pharmacy: Brand Name Prescriptions	$3.00	$3.00
Pharmacy: Generic Drug Prescriptions	$1.00	$1.00
Inpatient Hospital (acute)/day	$3.00 per day to a maximum of $21 per admission	$6.00 per day to a maximum of $42 per admission
Inpatient Hospital (rehab)/day	$3.00 per day to a maximum of $21 per admission	$6.00 per day to a maximum of $42 per admission
Outpatient Hospital	$1.00 per visit	$2.00 per visit
Emergency Room Services	None	None
Physician	None	None
Laboratory Tests	None	None
Skilled Nursing Facility	None	None
Waiver Services	None	Not covered
Nurse Midwife (maternity services)	None	None
Ambulance (non-emergency use)	None	None
CRNP	None	None
Disposable Medical Supply	None	None
FQHC/RHC	None	None
Home Health Agency Services	None	None
Family Planning	None	None
Rental of Durable Medical Equipment	None	None
Dentist	None	None
Podiatrist	None	None
Short Procedure Unit	$3.00 per admission	$6.00 per admission
Chiropractor	$1.00 per visit	$2.00 per visit
Ambulatory Surgical Center	$3.00 per admission	$6.00 per admission
Birth Center	None	None
Independent Med/Surgical Center	$3.00 per visit	$6.00 per visit
Optometrist	None	None
Renal Dialysis Center	None	Not covered
Hospice	None	None
Tobacco Cessation Counseling Services	None	None
Portable X-ray	$1.00	$2.00

Figure 4.1: *Health Partners Copayment Grid*

General Assistance (GA) members copayments are capped at $180.00 every six months while Medical Assistance (MA) members copayments are capped at $90.00 every six months. Once the cap is reached, Health Partners will reimburse members for the copayment amounts in excess of their capped rate.

Exceptions: DME & Medical supplies are only covered for GA population when prescribed for the purpose of family planning or in conjunction with home health services.

For questions and information on copays, please call Health Partners' Finance Department at **1-866-213-1681**.

Note: *Members who are under age 18, pregnant, or in a nursing home are not subject to these copays.*

Covered Services

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

Abortion Services

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

If the pregnancy was the result of rape or incest, a signed statement must be completed within the appropriate law enforcement jurisdiction. In the case of incest, when the victim is a minor, this statement must include the name of the law enforcement agency or child protective service where the report was made. If the provider believes the victim is not capable of reporting the incident, the provider must indicate the reason why on the Medical Assistance MA-3 form. When Part II of the MA-3 form is completed by the physician, a MA-368 form must be attached as well.

A copy of the Medical Assistance MA-3 form (and the Medical Assistance MA-368 form when required) must be attached to the claim for payment. PCP referral is not needed for abortion services.

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

Acupuncture

Health Partners covers acupuncture services for members age 16 and older. Services must be provided by a network provider specifically credentialed to perform acupuncture. Up to 20 visits yearly will be covered with a $5 copay for each visit. No referral or prior authorization is required.

Note: *Members who are under age 21 or pregnant are not subject to these copays.*

Allergy Testing and Treatment

The Primary Care Provider (PCP) is responsible for coordinating the treatment of allergies. A referral may be issued to a participating Health Partners allergist. The allergist must treat members within the scope of the referral requests only. The PCP and the allergist should agree upon a treatment plan and determine a schedule for patient visits to the allergist.

Once a desensitization program is initiated, the patient must return to the PCP for ongoing implementation of the treatment. In high-risk circumstances, by mutual agreement of the PCP and the allergist, the allergist may carry out the treatment plan. PCPs are reimbursed an additional fee above capitation for administration of allergy injections.

In maintenance therapy situations that are carried out in the PCP's office, the allergist should provide at least a six-month supply of serum. When a new bottle of serum extract is initiated, the allergist may administer the first injection with a single additional referral from the PCP. Allergist should use Procedure Code 95136 for preparation of serum (12-15 doses) or Procedure Code 95137 for preparation of serum (30-40 doses).

Allergy RAST testing is covered only when performed by the participating lab to which the member is capitated.

Ambulance

Health Partners covers all emergency ambulance services with qualified transport services. All non-emergent transportation service must be provided by a Health Partners-approved transportation service. All non-emergent services provided by non-participating transportation vendors will not be reimbursed without prior authorization from Health Partners. Also, see Transportation (Non-Emergent) on page 4-36.

Ambulatory Surgical Center/Short Procedure Unit

For a procedure to be considered an Ambulatory Surgical or Short Procedure Unit (SPU) procedure, the care must involve all of the following services: (1) an operating room procedure; (2) general, regional or MAC (Monitored Anesthesia, Conscious) anesthesia; and (3) recovery room services. The procedure must be performed in connection with covered services which have been referred by the PCP to the physician performing the procedure. Claims for Ambulatory Surgery and SPU procedures must be billed using the appropriate national standard for billing code type, revenue codes, and procedures for all three services. All other procedures will be considered Outpatient Services.

Cardiac Rehabilitation

The PCP or specialist can refer members who have a documented diagnosis of acute myocardial infarction within the preceding twelve (12) month period; had coronary bypass surgery; and/or have stable angina pectoris. These cardiac rehabilitation services are covered only in outpatient or home settings. No prior authorization is required.

Chiropractic Care

Services of a state-licensed chiropractor are covered only to provide treatment for manual manipulation of the spine to correct a subluxation demonstrated by x-rays. No authorization or referral is required.

Colorectal Screenings

Members who are age 50 and older are eligible for this screening to detect polyps and other early signs of colon and rectal cancer. PCPs are reimbursed fees above capitation for flexible sigmoidoscopy screening examinations. A referral is required to a specialist performing this service.

Dental

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

Members can receive dental services from a participating primary care dentist without a referral. All they have to do is choose a dentist from the list of dentists in the Health Partners Provider Directory. The primary care dentist will coordinate member referrals to periodontists and other dental specialists according to the policies defined by the dental subcontractor and approved by Health Partners.

Diabetes Self-Management Training and Education

Outpatient Diabetes Self-Management Training and Education services furnished to an individual with diabetes are covered by Medical Assistance when performed by a provider with Outpatient Diabetes Education Program recognition from the American Diabetes Association. For more information or for help finding a participating provider, the member or PCP should call the Provider Services Helpline or Member Relations department to self-refer (see Table 1: Service Department Contact Information on page 1-14).

Diabetes Self-Management Supplies

Formulary diabetic test strips, lancets, glucose meters, syringes, and alcohol swabs are covered under the pharmacy benefit. These supplies can be obtained from any Health Partners participating pharmacy with a prescription.

Dialysis

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

Please remember to submit a 2728-U form for members with end-stage renal disease (ESRD). If a 2728-U form is not filed, Health Partners will contact the dialysis center and request a copy.

Durable Medical Equipment (DME)

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

Key points to remember when prescribing DME items for Health Partners members:

- All purchased DME items or supplies (such as diapers, underpads, nebulizers) and outpatient services less than $500 per claim line DO NOT require prior authorization from Health Partners.
- All DME rentals require prior authorization, regardless of reimbursement value.
- If any portion of a purchased customized DME device has a reimbursement value greater than $500, an authorization is required for the entire DME device.
- All special items which do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Authorizations are based on benefit coverage/medical necessity.

If you have questions, please call the Health Partners Outpatient Services department during regular business hours. Providers who need help with urgent issues after business hours (about DME or such other outpatient services as discharge planning placements, home care, and transportation) can call Utilization Management (see Table 1: Service Department Contact Information on page 1-14) and leave a message, which will be forwarded to an on-call nurse case manager.

Emergency Care

Emergency care in emergency rooms and emergency admissions are covered in full by Health Partners for both participating and non-participating facilities, with no distinction for in or out -of-area services. Member is not responsible for any payments.

Non-par follow-up specialty care for an emergency is covered by Health Partners, but Health Partners staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible. Member is not responsible for any payments.

Emergency Services (Act 68)

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

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

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

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

EPSDT

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

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

Health Partners' Pediatric and Adolescent Preventive Care Flow Sheets, Screening Schedule, and Pediatric Immunization Schedule are designed to assist PCPs in delivering EPSDT-related services. (Please see Pediatric and Adolescent Preventive Health Guidelines in Chapter IX.) PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by Health Partners. Services not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration or scope, may be covered under this program. Contact Health Partners' EPSDT department for further information (see Table 1: Service Department Contact Information on page 1-14).

Providers are paid an additional administrative fee of $30 for each EPSDT screen (certain contractual exceptions may apply).

Family Planning

Family planning counseling services are covered by our Plan. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist or a Family Planning Council site. Members also have the option to self-refer to the Family Planning Council. Members are not required to obtain family planning services from an in-plan provider. For further information, providers can call (on behalf of their members) Health Partners Member Relations department (see Table 1: Service Department Contact Information on page 1-14).

Fitness Program

Members are eligible to enroll once a year in any of Health Partners' participating fitness centers, and can self-refer to these programs. For further information and direction, members should call the Member Relations Helpline (see Table 1: Service Department Contact Information on page 1-14).

Foot Care

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

Gynecological and/or Obstetric Examinations

The PCP may perform routine gynecological exams and/or make referrals to gynecologists as appropriate. Members may also self-refer for any routine gynecological and/or OB services.

Providers are encouraged to notify Health Partners as soon as a pregnant member is identified. Providers can simply fax (215-967-4492) or mail the initial perinatal assessment form, or call the Baby Partners to advise us of a pregnant member and/or members who are at risk of poor birth outcomes during business hours or our 24-hour Member Relations line to arrange to have their care coordinated by Health Partners' care management team (see Table 1: Service Department Contact Information on page 1-14).

Hearing Examinations

Audiometry/tympanometry is covered for children up to age 21. PCPs receive fees above capitation for audiometry/tympanometry. A referral is required, even if performed in the PCP's office.

Referrals to an audiologist require a referral from the member's PCP.

Home Health Care

Home care services are covered when medically necessary. Health Partners can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except the initial evaluation. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic therapy are also covered home care benefits if they have been authorized prior to the care.

Hospice Care

Health Partners will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in Health Partners even though they have elected hospice coverage. Members may continue to receive care unrelated to the terminal condition through Health Partners and may also use a Health Partners participating physician as their hospice attending physician. Medicaid will cover hospice services when:

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

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

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization (see Table 1: Service Department Contact Information on page 1-14).

Coverage includes:

- Physician and nursing services
- Medications including outpatient prescription drugs for pain relief and symptom management

- Physical, occupational and speech therapy
- Medical social services and counseling to beneficiary and family members
- Short-term inpatient care (for under 21), including respite care (a short stay intended to give temporary relief-up to five days in a row-to the person who regularly assists with home care) is covered while in hospice program.

Hospital Services

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

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

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

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

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

All hospitals that are contracted on a DRG basis must also notify Inpatient Services with an admission review within two business days. Using Interqual® criteria, the admission is approved (if it meets criteria) at the DRG rate for that facility. It is the responsibility of the hospital's case management department to contact Health Partners' Inpatient Services department with discharge dates and disposition of the patient. If the date of the admission or procedure changes, then Health Partners will need to be notified so that the authorization can match the incoming claim.

For those hospitals contracted for per-diem reimbursement, the Inpatient Services department performs daily reviews. If the chart is unavailable for Inpatient Services to conduct a review, then the Health Partners Inpatient Services case manager must be notified and a retrospective review of that day will be conducted the next business day. If a review cannot be obtained at this point, then the day will be denied based on untimely review.

Medical necessity for acute care hospitals is determined by application of Interqual® criteria. Health Partners does not reimburse acute care hospitals for services that do not require acute hospital levels of care. If the Inpatient Services department decision denies acute hospital levels of care, a written notice of denial is issued to the hospital. The notice includes instructions for pursuing an appeal of this determination. A facility that has been denied services should submit a letter of appeal and a copy of the medical chart within 30 calendar days to Health Partners' Inpatient Services department, Attn: Appeals Coordinator, 901 Market Street, Suite 500, Philadelphia, PA 19107.

The admitting physician may request an expedited appeal with the Medical Director. Physician-to-physician discussion is always available during the review process by calling **215-967-4570**.

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

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

Immunization Registries

The Philadelphia Department of Public Health sponsors the KIDS Immunization Registry which is a database of immunizations given to children in Philadelphia from birth through 18 years of age. Philadelphia Board of Health regulations require doctors in Philadelphia to report immunizations given to children from birth until age 19 to the registry. Kids Registry can be found at https://kids.phila.gov/

The Kids Registry Coordinator can be contacted for assistance at 215-685-6468.

For Montgomery, Chester, Bucks and Delaware Counties, vaccines are monitored thru the Pennsylvania Statewide Immunization System at: http://www.www.health.state.pa.us/pasiis or call 1-877-774-4748. Providers are encouraged to participate.

Injectables

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

For injectables covered under the pharmacy benefit, please see information about our Specialty Medication Program located in the Pharmacy entry in this section.

Laboratory

Outpatient laboratory services are provided through Quest Diagnostics. Locations of participating labs can be found online via PROVIDER *Plus*+ (*http://www.healthpart.com*). Physicians must complete the requisition form. Stat lab work may be ordered from a Health Partners participating hospital lab with a script. Laboratories must be CLIA-approved for participating in the Medical Assistance Program.

Mammograms

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

Medical Supplies

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

Medical Visits

Outpatient medical visits performed in a physician's office, hospital, skilled nursing facility or at home, by a Health Partners participating physician/provider, are covered. A PCP referral is needed for specialist visits.

Mental Health and Substance Abuse Treatment

Under HealthChoices, all Medical Assistance members, regardless of the HMO to which they belong, receive mental health and substance abuse treatment through the behavioral health managed care organization (BHMCO) assigned to their county of residence. For more information, see the Behavioral Health section on page 10 of Chapter 2.

PCPs who identify a Health Partners member in need of behavioral health services should direct the member to call his or her county's BHMCO. The BHMCO will conduct an intake assessment and refer the member to the appropriate level of care. Health Partners' Special Needs Unit is available to assist with this referral process.

Nebulizer Treatment

PCPs are reimbursed fees above capitation for nebulizer treatments performed in their offices.

Pharmacy

The Health Partners Medicaid drug benefit has been developed to cover medically necessary prescription products for self-administration in an outpatient setting. The Health Partners formulary and prior authorization processes are key components of the benefit design. Health Partners, through its Pharmacy Department, provides prescription benefits for our members with the use of a closed formulary. The Health Partners Formulary covers many generic drugs, whether listed or not, with exceptions for DESI (Drug Efficacy Study Implementation) drugs, medications used for weight gain or loss (except for drug products being used to treat

AIDS wasting and cachexia), and agents used for cosmetic purposes. Generic drugs must be prescribed and dispensed when an A-rated generic drug is available.

The drugs listed in the Health Partners Formulary are intended to provide broad options to treat the majority of patients who require drug therapy in an ambulatory setting. The medications included in the formulary are reviewed and approved by the Health Partners Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Health Partners provider community. The goal of the formulary is to provide safe and cost-effective pharmacotherapy based on prospective, concurrent, and retrospective review of medication therapies and utilization. The formulary is posted on our website at *http://www.healthpart.com/provider_formulary.asp*.

For additional printed copies, please call the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14)

Pharmacy Benefit Design

A maximum of a 34-day supply of medication is eligible for coverage in an outpatient setting. Refills can be obtained when 75% of utilization has occurred. The prescriber is urged to prescribe in amounts that adhere to FDA guidelines and accepted standards of care.

- Medicaid Program

  Copayments and prescription limits for adult members 18 years of age and older may apply, depending upon the member's benefit package. Pharmacy co-payments do not apply to members aged 0 - 17, members who are pregnant, and members who reside in a nursing home.

  The co-payment structure for prescription drugs are as follows:

  - $1.00 for formulary generic prescription drugs.
  - $3.00 for formulary brand name prescription drugs.
  - Copays will apply to any non-formulary drugs approved for prior authorization.
  - Certain benefit plans have a limit of six prescriptions per month.
  - Specific drugs within selected therapeutic categories will be excluded from the copay requirements for certain benefit plans.

  The formulary covers preferred, medically necessary prescription products and limited OTC medications. Certain over-the-counter drugs (e.g. aspirin, acetaminophen, vitamins, syrup of ipecac, hydrocortisone, guaifenesin) with an NDC code are covered with a doctor's prescription. Blood glucose test strips, alcohol swabs, syringes, and lancets (along with monitors, limited to 1 per year) are only covered through the pharmacy benefit with a prescription. The preferred diabetic supplies are Bayer HealthCare. Prescriptions for generically available non-prescription (OTC) drugs deemed medically necessary by the plan are eligible for coverage. Generally OTC medications are less costly than prescription alternatives and their use can contribute to cost-effective therapy. The over-the-counter (OTC) products listed in the formulary are covered with a written prescription.

Pharmacy Prior Authorization

There may be occasions when an unlisted drug is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through Prior Authorization/Medical Exception.

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

- Non-formulary medications, or benefit exceptions requested for medical necessity
- Medications and/or treatments under clinical investigation
- Duplication of Therapy Edits will be hard coded to assure appropriate utilization of multiple drugs within the same therapeutic categories (e.g., duplication of two SSRIs).
- All brand name medications when there is an A-rated generic equivalent available
- Prescriptions that exceed set plan limits (days supply, quantity, refill too soon, and cost)
- New-to-market products prior to review by the P&T Committee
- Orphan Drugs/Experimental Medications
- Selected injectable and oral medications
- Specialty medications
- Drugs that exceed $1,000 in cost per prescription

To request a prior authorization the physician or a member of his/her staff should contact Health Partners. All non-emergency requests can be faxed (**866-240-3712**) 24 hours per day; calls should be placed from 9:00 A.M. to 5:00 P.M., Monday through Friday. In the event of an immediate need after business hours, the call should be made to Health Partners' Member Services Helpline (see Table 1: Health Partners Benefits on page 4-6). The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

The physician may use the Health Partners Prior Authorization/Medical Exception form or a letter of request, but must include the following information for quick and appropriate review to take place:

- Specific reason for request
- Name and recipient number of member
- Date of Birth of member
- Physician's name, license number, and specialty
- Physician's phone and fax numbers
- Name of primary care physician if different
- Drug name, strength, and quantity of medication
- Days supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis
- Formulary medications used, duration and therapy result
- Additional clinical information that may contribute to the review decision

Copy-ready prior authorization forms are included in the Appendix of this manual. All prior authorization forms are also available on the Health Partners website at *http://www.healthpart.com*.

Upon receiving the Prior Authorization Medical Exception Request from the prescriber, Health Partners will render a decision within 24 hours. Approval or denial letters are mailed to the member or parent/guardian, in the case of a child. A copy of the member denial letter will also be mailed or faxed to the prescribing physician. At

anytime during normal business hours, the prescribing physician can discuss the denial with a clinical pharmacist or can have a peer to peer discussion with the medical director by calling the pharmacy department.

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

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

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

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

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

Specialty Medication Program

Health Partners supports appropriate use of specialty medications (high end injectables and oral medications) and has established procedures for prescribing and suppliers. Under the direction of the Health Partners Pharmacy department, the physician provider has the primary responsibility for obtaining prior authorization for medications included in this program. The prescribing physician will need to send the completed medical request with all pertinent lab information to the Health Partners Pharmacy department by fax to **866-240-3712** or **215-849-2150**. Providers that are contracted to provide medications in the office and who carry the medication for patient administration can submit claims for payment without prior authorization.

In addition, the prescriber can always call Health Partners Pharmacy department for assistance with the prior authorization on specialty medications.

Copy-ready Specialty Medication prior authorization forms are included in the Appendix of this manual. All prior authorization forms are also available on the Health Partners website at *http://www.healthpart.com*.

Medications that can be obtained through the retail pharmacy benefit without prior authorization may include, but are not limited to, the following:

- Diphenhydramine
- Imitrex
- Insulin
- Depo-Provera 150 mg for contraception
- Epinephrine (bee sting kits)
- vitamin B-12
- heparin
- ceftriaxone
- triamcinolone
- methylprednisolone
- haloperidol decanoate
- fluphenazine decanoate
- Glucagon Emergency Kit
- Penicillin G

Specialty medications are processed through the pharmacy department and require a prior authorization/medical exception. This list includes, but is not limited to, the following specialty medications:

- Fuzeon
- Gleevec
- Lupron
- Synagis
- Synvisc
- Arixtra
- Revlimid
- Neulasta
- Thalomid
- Tykerb
- Avonex
- Neupogen
- Tysabri
- Humira
- Nexavar
- Xolair
- Botox A
- Hyalgan
- Norditropin

- Ribavirin
- Zoladex
- Copaxone
- Infergen
- Risperdal Consta
- 17-alpha hydroxyprogesterone caproate
- Enbrel
- Intron A
- Pegasys
- Epogen
- Serostim
- Forteo
- Lovenox
- Procrit
- Supartz

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

Members may be referred by the PCP for outpatient PT/OT/ST to a participating Health Partners provider. Prior authorization is required for all outpatient PT/OT/ST. Prior authorization is not required for outpatient evaluation.

Preventive Health Services

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

Prosthetics/Orthotics

Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the Health Partners Outpatient Services department. Orthotics and customized devices require prior authorization.

Radiation Therapy

Radiation therapy services are covered, when referred by the PCP. Inpatient services require prior authorization by Health Partners.

Rehabilitation

Please see alphabetized listings under "Comprehensive Outpatient Rehabilitation Facility (CORF)" and "Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)." Inpatient rehabilitation requires a prior authorization.

Respiratory Therapy

Respiratory therapy services are covered when referred by a PCP, and provided by a licensed respiratory therapist in a network facility.

Sigmoidoscopy

Please see alphabetized listing under "Colorectal Cancer Screening."

Skilled Nursing Facility

Services for inpatient care in a Health Partners participating skilled nursing facility must be prior authorized by Health Partners' Inpatient Services department. Members are covered for up to 30 days. Please note that bed "hold" days at nursing homes count towards this 30-day period. On the 31st day of care, members are automatically reverted to Medical Assistance fee-for-service and services are then covered directly by DPW. Members requiring extended care services in a skilled nursing facility or intermediate care facility for more than 30 days will be disenrolled from Health Partners program and enrolled in the Medical Assistance fee-for-service program.

Smoking Cessation

Various smoking cessation services are available to our members to assist them in quitting smoking. Please referrence our website at www.healthpart.com for the most current reimbursable expenses.

Specialist Visits

PCP referrals to Health Partners participating specialists and other providers are covered. Referrals to non-Health Partners participating physicians and other licensed allied health personnel will be covered only when issued by the PCP and prior authorized by Health Partners. The referral is valid for sixty (60) days from the date of issue.

A PCP is not restricted regarding the specialist referral criteria (i.e. length of time the member sees the specialist or the number of visits that comprises). If the specialist does not participate with Health Partners, the referral is based upon prior authorization and these claims are adjudicated accordingly. PCP's are expected to keep all referrals on file in the patient's record. Members are given a copy of the referral to bring to the specialist office to confirm that the PCP made the referral.

Sterilization

Such sterilization procedures as tubal ligation and vasectomy are covered with no prior authorization required when provided as outpatient services to Health Partners members age 21 or older. Prior authorization is required if these services are provided on an inpatient basis. A properly completed MA-38 form documenting the

member's voluntary informed consent must accompany the provider's claim for payment for all sterilization services.

Hysterectomy is not covered if solely for sterilization purposes. If medically necessary, the provider must request prior authorization.

Suturing

PCPs are reimbursed fees above capitation for suturing performed in their offices.

Transportation (Non-Emergent)

Non-emergent transportation services require prior authorization.

Health Partners members are eligible for registration with the DPW Medical Assistance Transportation Program (MATP). MATP can provide help with health-related transportation, including to and from doctor visits. To facilitate the process, members and providers must be registered with their respective county's MATP provider. MATP will determine transport eligibility (reimbursement, paratransit or mass transit) based on the medical assessment supplied by the provider. Members can call their county's MATP provider to arrange transportation, or may call Member Relations. Providers may arrange transportation by calling the Special Needs Unit. For more information, see Table 1: Service Department Contact Information on page 1-14.

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

Vaccines for Children (VFC) program

Providers in Philadelphia County must obtain their vaccine thru the Philadelphia VFC program at

https://www.health.state.pa.us/vfc or call 888-646-6864. Please be aware that, for Health Partners providers, participation in the VFC program is required if you see eligible members in the age ranges of 0 through 18. Providers should submit claims with the vaccine codes to be paid the administrative fee.

For providers outside Philadelphia County, they should obtain their vaccine from the state VFC program at 1 - 888-6864 or at the website for the PA Department of Immunizations at:

http://www.portal.state.pa.us/portal/server.pt/community/immunizations/14141/vaccines for children %28vfc%29 program/557983.

Vision Care

Health Partners covers routine eye examinations for all members. Members do not need a referral from their PCPs if they use a participating provider. However, members must have a referral from their PCPs to see an eye care specialist for services other than routine eye exams.

For members under 21, EPSDT services are covered as medically necessary. Members receive a maximum of 2 pairs of eyeglasses (consisting each of one frame and two lenses) as well as replacement pairs if medically necessary; or two pair of contact lenses; or one pair of each per year.

Note: *Contact lenses are an enhanced benefit and are not covered by Medical Assistance except when a member is diagnosed with aphakia or cataracts for members 21 and over.*

Health Partners does not cover prescription eyeglasses or prescription contact lenses for members age 21 and older, with the following exceptions:

- For members diagnosed with cataracts, two pairs of prescription eyeglass lenses and frames or prescription contact lenses are covered yearly.
- For members diagnosed with aphakia (where the eye lens is missing), two pairs of prescription eyeglass lenses and frames or prescription contact lenses or one pair of each are covered yearly

Note: *Replacement eyeglasses or contacts for members with cataracts or aphakia are limited to one pair per year.*

- For members diagnosed with diabetes, one pair of prescription eyeglass lenses and frames or prescription contact lenses are covered yearly through Health Partners' "Diabetic Eyes for Active Living (DEAL)" program. (Dilated eye exam required for coverage.)

Members can choose an eye care provider from the Health Partners Provider Directory.

Non-Covered Services

The following services and benefits are excluded or limited under the Health Partners plan.

- Artificial insemination/infertility treatment
- Cosmetic surgery, except to correct a serious disfigurement or deformity caused by disease or injury that occurred while the patient was a participating member; or for the treatment of congenital anomalies to restore a part of the body to its proper function
- Health club memberships except when stipulated by contract with Health Partners
- Personal convenience items or services
- Reversal of tubal ligation
- Services available through other programs such as workers' compensation, Veterans Administration, other governmental programs/agencies or other insurance coverage
- Services for which neither the member nor another party on his or her behalf has any legal obligation to pay

- Services not provided by, or arranged through a provider, medical office, or dental office participating with Health Partners, except for emergency services or services that may be self-referred-unless authorized by Health Partners
- Services not reasonable or medically necessary for the diagnosis or treatment of an illness or injury, or for restoration of physiologic function (except preventive services)
- Services performed by immediate relatives of members, or by others in the member's household
- Transportation services, other than those Ambulance and Non-Emergent Transportation services described under Health Partners Covered Services in this section.

Note: *Health Partners will not cover services that are harmful to members, are of inferior quality or are medically unnecessary as may be the case with a serious and clearly preventable adverse event. In addition, financial compensation for any and all services rendered as a result of or increased by a preventable serious adverse event will be withheld or recovered.*