6 Health Partners Provider Manual
Utilization Management

Purpose: This chapter provides an introduction to Health Partners' Utilization Management team and the guidelines and criteria used by the department to achieve optimal benefit utilization for our members.

Topics:

- Health Partners' commitment to providing appropriate medical care for members
- Prior authorization rules and guidelines
- Utilization Management decision process and criteria
- Appeals process

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Overview

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

- pre-certification review
- admission review
- concurrent review
- retrospective review
- discharge planning
- bill review
- individual medical case management

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

Due to possible interruptions of a Member's State Medical Assistance coverage, it is strongly recommended that Providers call for verification of a Member's continued eligibility on the 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 submit clinical information justifying medical necessity for continuation of services to Health Partners' Inpatient and Outpatient Services Departments to obtain Prior Authorization for continuation of service.

Providing Appropriate Medical Care for Members

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

Medically Necessary Services

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 Review, or exception basis, must be documented in writing.

The determination is based on medical informtion provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical necessity is not considered to be providing a health care service under this Agreement.

CHIP: Medical Necessity or Medically Necessary and Appropriate refers to services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

HealthChoices Clinical Sentinel Hotline

The Clinical Sentinel Hotline (CSH) is operated by DPW to ensure requests for Medically Necessary care and services to Health Partners and the appropriate BH-MCO are responded to in a timely manner.

The CSH is answered by nurses who work for DPW. If a Health Care Provider or Member requests medical care or services, and Health Partners 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 CSH if Health Partners or the BH-MCO has denied Medically Necessary care or services or will not accept a request to file a Grievance.

The CSH operates Monday through Friday between 9:00 a.m. and 5:00 p.m. Call **1-800-426-2090**. The CSH cannot provide or approve urgent or emergency medical care.

Prior Authorizations

The following information is provided to Health Partners/KidzPartners members so that they are aware of the prior authorization process and timeframes. If you, as a provider, have any questions about the information below, please call the Provider Services Helpline at **215-991-4350** or **1-888-991-9023**.

Sometimes there are services or items that your PCP (primary care provider) must ask Health Partners to approve for you. This is known as prior authorization. These services include, but are not limited to:

– All scheduled hospital admissions

– Medical equipment like wheelchairs and repairs

– Outpatient Physical Therapy/Occupational Therapy/Speech Therapy

– Homecare

– CT, MRI, PET scans

– Non-Emergent Transportation

The timeframe in which Health Partners has to respond to prior authorization requests are as follows.

– Immediate: In Patient Place of Service “Review” for emergency and urgent admissons.

– 24 hours: All drugs; and items or services that must be provided on an urgent basis.

– 48 hours:(Following receipt of required documentation): Home Health Services.

– 21 days: all other services

– When Health Partners/KidzPartners receives a complete request for prior authorization, we will contact you by phone within 48 hours of the date of the request for service. A written decision notice will be mailed to you within two business days from the date of our decision

– Health Partners/KidzPartners will notify the health care provider within 48 hours of the request for service of additional facts, documents or information required to complete the UR. If your provider does not send the additional information within 14 calendar days of our request for more information, then we will base our decision on the information available.

– If you do not receive written notification of our decision within 21 calendar days from the date Health Partners received the prior authorization request, the service or item is automatically

approved. Additionally, Health Partners/KidzPartners members have the right to appeal any prior authorization request that was denied within the required timeframes.

Prior Authorization Guidelines

For Health Partners members, prior authorization by Health Partners' Inpatient Services department is required for all elective hospitalizations, transfers to non-participating facilities, skilled nursing admissions, acute rehab admissions, inpatient hospice admissions, and advanced radiology services (CT, MRI and PET scans). Prior authorization is also required for certain SPU/Ambulatory services (see Table 1: Short Procedure Unit (SPU)/ Ambulatory Procedures on page 6-8).

For KidzPartners members, prior authorization by Health Partners' Inpatient Services department is required for all elective hospitalizations (including Mental Health), transfers to non-participating facilities, skilled nursing admissions, acute rehab admissions, inpatient hospice admissions, and advance radiology services (CT, MRI and PET scans) and short procedures performed in a hospital or ambulatory surgical center.

For both programs, requests for elective admissions and transfers to non-participating facilities not authorized by Health Partners before admission will be denied for payment. A denial letter will be issued for all elective admissions and transfers to non-participating facilities not authorized by Health Partners. For denial reconsideration, the facility must submit, within thirty days, a letter of appeal detailing why prior authorization has not been obtained. The address for appeals is:

Attn: Inpatient Services/Appeals
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

Health Partners will respond to the appeal for medical necessity within 30 days. If not overturned, a second appeal must be submitted by the facility within 30 days of the first level decision notification.

All administrative denials are to be addressed to:

Attn: Director, Inpatient Services
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

In the Health Partners program, certain Short Procedure Unit (SPU)/Ambulatory procedures are subject to scrutiny because they are often performed for cosmetic purposes (and so are excluded from coverage), rather than for medical necessity reasons. As a result, if these services are billed, medical records will be requested to validate the medical necessity of the procedure.

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

Code	Description
30430	Rhinoplasty for Nasal Deformity
30462	Rhinoplasty for Nasal Deformity
67930	Suture of Recent Wound, Eyelid
67935	Suture of Recent Wound, Eyelid

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

Code	Description
67938	Removal of Embedded Foreign Body, Eyelid
67950	Canthoplasty
67961	Excision and Repair of Eyelid
67966	Excision and Repair of Eyelid
67971	Reconstruction of Eyelid
67973	Reconstruction of Eyelid
67974	Reconstruction of Eyelid
67975	Reconstruction of Eyelid
67999	Unlisted Procedure, Eyelid
19328	Removal of Intact Mammary Implant
19330	Removal of Mammary Implant Material
19340	Immediate Insertion of Breast Prosth Follow
19342	Delayed Insertion of Breast Prosth Follow
19350	Nipple/Areola Reconstruction
19355	Correction of Inverted Nipples
19357	Breast Reconstruction, Immed or Delay
19361	Breast Reconstruction with Latis Dorsi Flap
19364	Breast Reconstruction with Free Flap
19366	Breast Reconstruction with Oth Tech
19367	Breast Reconstruction with Trans Rect
19368	Breast Reconstruction with Microvas Anast
19369	Breast Reconstruction with Trans Rect
19370	Open Periprosthetic capsui, Breast
19380	Revision of Reconstructed Breast

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

Code	Description
19396	Preparation of Moulage for Custom Breast
11960	Insertion of Tissue Expander With
11970	Replacement of Tissue Expander
11971	Removal of Tissue Expander Witho
54406	Removal of all components of a Mult
54408	Repair of Component (s) of a Multi-C
54415	Removal of a Non-Inflatable
54152	Circumcision except newborn
54161	Circumcision except newborn

Note: *All SPU/Ambulatory services for KidzPartners members require prior authorization.*

How to Obtain Prior Authorization

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

For elective admissions and transfers to non-participating facilities, the PCP, referred specialist, or hospital must call Health Partners' Inpatient Services department (see Table 1: Service Department Contact Information on page 1-14). These requests for prior authorization must be made before the anticipated admission. Please include the following:

- Member's name and Health Partners or KidzPartners ID number
- Scheduled date of hospital admission
- Anticipated length of stay for hospital admission
- Name of attending physician
- Diagnosis (be as specific as possible)
- Procedure (be as specific as possible)
- Supporting clinical/medical information for requested procedure
- Admitting hospital

For Home Care and Physical Therapy/Occupational Therapy/Speech Therapy authorization, please fax requests to the Outpatient Services department at **215-967-4491**.

For DME and Transport (ambulance) authorization, fax requests to **215-849-4979**.

Inpatient and maternity cases can be submitted through our secure Provider Portal, HP Connect.

Note: *Due to circumstances regarding member eligibility and timeliness standards, an authorization is not a guarantee for payment.*

Advanced Radiology Services Prior Authorization

Health Partners is partnering with MedSolutions to provide prior authorization review of select high-tech outpatient elective diagnostic imaging procedures for Health Partners and KidzPartners members. Beginning on January 1, 2010, prior authorizations for advanced outpatient radiology services (CT, MRI and PET scans) will be managed by MedSolutions, Inc.

Prior authorization requests for outpatient diagnostic imaging procedures are obtained by contacting MedSolutions, Inc. at **888-693-3211** or by fax at **888-693-3210** during normal business hours, 8:00 AM to 9:00 PM ET. Requests for prior authorizations may also be submitted via MedSolutions' secure website at *www.MedSolutionsOnline.com*.

The MedSolutions web portal may provide you with an immediate approval depending on the type of service requested. The portal also has helpful radiology reference information for your office such as a complete CPT code list, diagnostic code list, and specific guidelines to assist you in determining the most appropriate imaging for your patient's condition.

Inpatient UM Process

Health Partners uses available InterQual criteria for the review and decision making of

- elective and emergent inpatient admissions
- SNF/rehab admissions
- inpatient hospice
- SPU services
- radiology services

Providers can request a copy of specific Inpatient Criteria, or information about criteria by calling Health Partners Inpatient Services (UM Manager) at 215-991-4188. To request a copy of specific Health Partners Outpatient Criteria or information about criteria, please contact the Outpatient Services Manager at 215-967-4566. For prior authorization, please call 215-967-4690 or 1-866-500-4571 (toll free).

Obtaining Inpatient UM Assistance After Business Hours

All admissions are to be called in to Health Partners' Inpatient Services department during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m.

All after-hours referrals should be directed to participating facilities. If providers require assistance for urgent issues after business hours, please call **215-967-4690** or **866-500-4571** and leave a message, which will be forwarded to an on-call nurse case manager. If services (including transfers) cannot be obtained from a Health Partners participating provider, these services must be prior authorized.

Transfer Admissions

All hospital transfers should be directed to Health Partners/KidzPartners participating facilities. If services are not available within the network, prior authorization is required prior to the transfer. Transferring facilities can obtain prior authorization by calling Inpatient Services during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m (see Table 1: Service Department Contact Information on page 1-14). After usual business

hours, please call **215-967-4690** ot **866-500-4571** and leave a message for the on-call Inpatient Services Case Manager.

Elective Admissions

All elective hospital admissions should be performed by a Health Partners/KidzPartners participating physician. To maximize continuity of care, the PCP or specialist should direct care to the PCP's affiliated health system. Please refer to your directory or PROVIDER Plus+, our online Provider Directory, for more information.

The PCP issues a referral for elective hospital admissions to the admitting physician. Health Partners' Inpatient Services department issues a written and verbal notification (including an authorization number) to the hospital when prior authorization is approved.

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

Emergent Admissions

All admissions, whether elective or urgent, must be reported to the Health Partners Inpatient Services department within two business days of admission. This notification must include an initial clinical review. Failure to meet this time frame will result in a denial for untimely notification.

Emergency Care

Emergency care in emergency rooms and emergency admissions are covered services for both participating and non-participating facilities, with no distinction for in or out -of-area services.

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.

Concurrent Review Process

All hospitals that are contracted on a DRG basis will contact Inpatient Services within two business days. Using Interqual® Level of Care criteria, the admission is reviewed and if it meets criteria, the admission is approved. Once approved, a next review date will be given. When the “working DRG” trim point has been met, then daily reviews are to be conducted until discharge. 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 procedure changes, then Health Partners will need to be notified so that the authorization can match the incoming claim.

Hospitals contracted for per-diem reimbursement are responsible for calling the Health Partners Inpatient Services department within two (2) business days. The Inpatient Services department performs daily reviews. If the chart is unavailable to conduct a review, then the Health Partners case manager must be notified and a retrospective review of that day will be conducted the next business day.

Failure to provide clinical information by the next assigned review date will result in a denial for untimely clinical review.

Medical necessity for acute care hospitals is determined by using the Interqual® Level of Care 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 or reduces 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. The HP Medical Directors are available to discuss utilization review decisions with peers by calling **215-967-4570**.

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

Attn: Utilization Review/Appeals
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107.

The PCP (or the covering hospital physician) 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.

Notification of Discharge/Discharge Management

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

Health Partners will continue to look to the PCP for all issues related to appropriate utilization. PCPs are responsible for coordinating follow-up care after hospital discharge. They may refer members to participating specialists when this is medically appropriate. The first, post-surgical follow-up visit is included in the initial referral for surgery. Referral to a specialist or surgeon does not relieve the PCP of his or her responsibility to remain involved in the care of the member.

Skilled Nursing Admissions

Health Partners - Medicaid: Members in a licensed skilled nursing or intermediate care facility are covered by Health Partners for up to 30 days (including bed hold days). Members can be admitted to skilled or intermediate care facilities directly from the community.

KidzPartners- CHIP: For KidzPartners, there is a limit of ninety days annually for inpatient medical, skilled nursing and mental health combined.

All admissions will require prior authorization by the Inpatient Services department for reimbursement. Requests for skilled nursing admissions should be faxed to **215-991-4125**.

For Health Partners members only, the 30-day period includes any hospitalizations or transfers between skilled nursing facilities (SNFs). Health Partners will submit an involuntary disenrollment request of the member from the plan to DPW if the member has not been discharged from the SNF to a community placement.

Outpatient Services UM Process

Authorization requirements may vary depending upon whether or not the services rendered take place in an inpatient or outpatient setting. The following section provides an overview of common outpatient procedures requiring prior authorization and how that authorization is obtained. Outpatient services include, but are not limited to, the following:

- Outpatient Therapy Services (physical, occupational, speech)

  Prior Authorization is not required for initial evaluations
- Home Health Services
- Home Hospice
- All DME rentals
- All DME purchases over $500 with the following exceptions:
- Any service(s) performed by Non-Participating Providers.
- Any service/product not listed on the Medical Assistance Fee Schedule including EPSDT Expanded Services.
- Air Ambulance (reviewed retrospectively for medical necessity)
- Non-emergent transportation

Obtaining Outpatient UM Assistance After Business Hours

Health Partners' Outpatient Services department’s normal business hours are Monday through Friday, 8:00 a.m. to 4:30 p.m.

Note: *Any requests needed after business hours, please call 215-967-4690 or 866-500-4571 and select Outpatient Services prompts to leave a message, which will be forwarded to an on-call nurse case manager.*

Ambulance/Non-Emergent Transportation

Health Partners is responsible to coordinate and reimburse for medically necessary transportation by ambulance for physical, psychiatric or behavioral health services.

Health Partners has contracted with specific Ambulance providers throughout the service area. All non-emergent ambulance transportation must be prior authorized. Request forms and physician certification forms can be located at *http://www.healthpart.com* for submission for prior authorization. Once completed, they can be faxed to **267-515-6627**.

Health Partners will assist members in accessing non-ambulance transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP), however Health Partners 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 transportation for behavioral health appointments.

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

Durable Medical Equipment and Medical Supplies

Health Partners members are eligible to receive medically necessary durable medical equipment (DME) needed for home use. Coverage of DME may be based on a member's benefit package. Please see the benefits coverage grid on page 4-23.

All DME purchases and medical supplies over $500 and all DME rentals must be prior authorized.

PCPs, Specialists and Hospital Discharge Planners are directed to contact Health Partners Outpatient Services Department at 215-967-4690 or 1-866-500-4571. Because members may lose eligibility or switch plans, DME Providers are directed to contact the Provider Helpline at 215-991-2172 for verification of the member's continued Medical Assistance eligibility and continued enrollment with Health Partners 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 MA Program. Health Partners will reimburse participating DME Network Providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies not covered by the MA Program but covered under Title XIX of the Social Security Act, provided that the equipment or service is medically necessary and the Network Provider has received Prior Authorization from Health Partners. In order to receive Prior Authorization, the requesting Network Provider can fax a completed request form and letter of medical necessity to Health Partners DME at 215-849-4749. Forms can be found at www.healthpart.com website under the Providers form section.

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; and
- other failed therapies, etc.

Each request is reviewed by a Health Partners Medical Director for medical necessity. Occasionally, additional information is required and the Network Provider will be notified by Health Partners of the need for such information. If you have questions regarding any DME item or supply, please contact the DME Unit at 215-967-4690 or the Provider Services Department at 215-991-2172.

Medical Supplies

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

- Vaporizers (one per calendar year)- Covered under Pharmacy benefit for under 21
- Humidifiers (one per calendar year)-Covered under Pharmacy benefit for under 21
- Diabetic supplies - Covered under Pharmacy benefit.
- Insulin, disposable insulin syringes and needles
- Disposable blood and urine testing agents
- Glucose Meters, Alcohol Swabs, Strips and Lancets

- Diapers/Pull-Up Diapers may be obtained as follows:
- members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary;
- a written prescription from participating practitioner is required;
- generic diapers/pull-up diapers must be dispensed; and
- brand diapers/pull-up diapers require Prior Authorization and Letter of Medical Necessity (LOMN)

Home Health Services

Prior authorization for initial evaluations for homecare/hospice services are not required. Once a member has had an initial evaluation, prior authorization will be required for further treatment of the member. If no further treatment is necessary, the initial evaluation request (physician orders [verbal accepted but must be noted and signed as such by RN] or prescription) must be faxed (215-967-4491) within five business days of initial visit in order to get paid for initial visit. The initial evaluation date must be included in the dates of service on your authorization request and cannot be billed for without the authorization number for the following services.

- Skilled nursing (RN/LPN)
- Infusion therapy
- Home Health Aide
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Health Partners 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 in greater comfort, because they are in familiar surroundings.

Health Partners' Outpatient Unit will coordinate medically necessary home care needs with the PCP, attending specialist, hospital home care departments and other providers of home-care services. Please fax in your request form to Health Partners' Outpatient Services Unit at 215-967-4491 to obtain an authorization. Request forms can be found at www.healthpart.com under the provider section.

Hospice Care (Outpatient)

If a member requires hospice care, the PCP should contact Health Partners' Outpatient Services Unit. Health Partners will coordinate the necessary arrangements between the PCP and the hospice provider in order to ensure receipt of medically necessary care. Request must include a signed prescription/order COTI (consent by member (not the Medical Director of the servicing hospice).

Use home care/ hospice request form (may download this form from www.healthpart.com).

Health Partners' Inpatient and Outpatient Departments can be reached at Telephone Number is 1-866-500-4571 or 215-967-4690.

Orthotics and Orthopedic Shoes

Health Partners has the following benefit limitations for members age 21 or older:

- Orthopedic shoes will not be covered unless have a diabetic diagnosis.
- Orthopedic shoes for diabetic purposes will be covered once per year from date of service.
- Orthopedic devices will be covered once every three years from date of service.

Prior authorization will not be required for members 21 and older due to limitations.

Prior authorization for members under age 21 requiring orthopedic shoes and devices over $500 will continue to be required. Requests for orthotics and/or shoes should be faxed to 215-849-4749.

Physical, Speech and Occupational Therapies

Health Partners requires prior authorization of all outpatient rehab services except for the initial evaluation and re-evaluations. A member may seek an initial evaluation with a valid prescription at a participating outpatient rehabilitation provider. If continuation of therapy is warranted, the servicing provider must submit the initial evaluation with a request for more visits.

Servicing providers can submit the evaluation and request via fax to **1-215-967-4491**. Health Partners has two business days to render a decision. A decision can be an "approval," "denial" or "pending for additional information." Services should only be rendered with an approved authorization.

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 DPW's approved State Plan. EPSDT Expanded Services may include items such as medical supplies or Enteral formula or shift care services, 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 Health Partners benefits.

EPSDT Expanded Services Requiring Prior Authorization

EPSDT Expanded Services require Prior Authorization. All requests for EPSDT Expanded Services should be forwarded to Health Partners Outpatient Services Unit where they will be reviewed for medical necessity. Requests should be accompanied by a letter of medical necessity outlining the rationale for the request and the benefit that the requested service(s) will yield for the member. DME and medical supplies requests should be faxed to 215-849-4749 and requests for shift care services (private duty nursing) should be faxed to **215-967-4491**.

EPSDT Expanded Services Approval Process

When the Health Partners 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 Health Partners Outpatient Services Department at 215-967-4690. The provider of service will be responsible for obtaining authorization to extend the approval of services prior to the end date of current authorization. The provider of service is also responsible for verifying the member's eligibility prior to each date of service.

EPSDT Expanded Services Denial Process

Prior to denying any request, the Health Partners Medical Director or his/her designee will make two attempts, as an effort of good faith, to contact the requesting Network Provider to discuss the case. If the request is denied in full or in part, a letter detailing the rationale for the decision will be sent to the member, the requesting Network Provider, and if identified, the provider of service or advocate working on the behalf of the member. This letter will also contain information regarding the grievance or appeal process and for members, information on how to contact community legal service agencies who might be able to assist in filing the Grievance.

Health Partners will honor EPSDT Expanded Service treatment plans that were approved by another HealthChoices Managed Care Organization or DPW prior to the member's Enrollment with Health Partners. The Health Care Provider of service is responsible for forwarding documentation of the prior approval in order for Health Partners to continue to authorize previously approved services. Health Partners will not interrupt services pending a determination of medical necessity in situations where the Health Care Provider is unable to document the approval of services by the previous insurer.

Medicaid Program Exception Process

Health Partners, under extraordinary circumstances, will authorize a medical service or item that is not one for which the Medicaid Program has an established fee, or will expand the limits for services or items that are listed on the Medicaid Program Fee Schedule. If a provider concludes that lack of the service or item would impair the member's health, the provider may request a program exception. A request for program exception must contain sufficient information to justify the medical necessity for all requested services.

Program Exception is allowed for review of requests for:

- Services and items not listed on the Medical Assistance Fee Schedule, if they are types of services/items covered by the Medical Assistance Program and generally accepted by the medical community
- Expansion of coverage limitations for services/items that are listed on the Medical Assistance Fee Schedule
- Coverage under Program Exception is not allowed when the service, item or limits on the service/item is prohibited from payment by statute or regulation.

Medicaid Inpatient Benefit Limit Exception

Inpatient acute hospital benefit limits have been removed from General Assistance (GA) membership benefit packages. Inpatient acute rehabilitation stays will continue to have a benefit limit of one inpatient stay per benefit year.

A request for an exception may be made prospectively, before the service has been delivered, or retrospectively, after the service is delivered. The following timeframes will be adhered to in addressing benefit exception requests:

- Prospective Urgent benefit exception requests: two business days.
- Prospective benefit exception requests : two business days of receipt of complete information . If additional information is required the provider has 14 calendar days to submit information.
- Decision will be rendered within 2 business days of the receipt of additional information with written notification generated within 2 business days of communicating the decision. Written notification is to be received by the member within 21 days.
- Retrospective exception requests: 30 days.

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

A provider or member can request an exception to the Benefit Limit within the member's MA/GA Benefit Package within 30 days from the date notice is received.A request form will be issued to the member and provider for completion. It details the medical information needed to process the request and make a determination.

The provider should send the completed form and any other information he/she deems important to:

Attn: UM/Benefit Exception
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

Exceptions will be reviewed according to approved guidelines, such as:

- The member has a serious chronic systemic illness or other serious health condition and without the additional service the member's life would be in danger, or
- The member has a serious chronic illness or other serious health condition and without the additional service the member's health will get much worse, or
- The member would need more costly services if the exception is not granted, or
- The member would have to go into a nursing home or institution if the exception is not granted.
- Approved Exceptions will be processed according to the Prior Authorization policy and procedures.

The inpatient benefit limit exception process applies only to Medicaid members not KidzPartners members. Prior authorizations are based on covered services under a given benefits package, medical necessity, and clinical appropriateness using clinical criteria and guidelines that are the accepted standard of care in the medical community. In addition, the physician reviewer must override the criteria when, in his/her professional judgment, the requested service is medically necessary. Individual member assessment must occur. Health Partners will review exceptions to benefit limitations using approved guidelines.

Note: *The inpatient benefit limit exception process applies only to Medicaid members not KidzPartners members.*

Appealing Inpatient Utilization Review Decisions

Any disagreement between Health Partners and a facility concerning concurrent or retrospective denials based on procedural errors or medical necessity/appropriateness, and in which the member received service(s) and is held financially harmless, shall be resolved in accordance with the following appeal procedures:

In the event a case is referred to the Health Partners Medical Director or physician advisor for a determination, and the initial decision is adverse to the facility's request, the facility may request an expedited appeal within 24 hours of the decision by calling 215-967-4570.

The facility will be notified in writing of the expedited appeal decision rendered by the Health Partners Medical Director. The facility shall have thirty (30) calendar days from the date of the written decision notification from the Health Partners Medical Director to request a first level of appeal by submission of the medical record and a letter of appeal, to:

Attn: Inpatient Services /Appeals
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

If the denial is upheld in the first level of appeal, then the facility has thirty (30) calendar days from the date of the written notification to request a second level appeal from the Utilization Management Committee at the Appeals address above.

The Utilization Management Committee (UMC) is a subcommittee of the Health Partners Medical Affairs Committee, which serves as a peer review panel and is composed of representatives from Health Partners' participating providers. The Utilization Management Committee responds to second level appeals. The UMC will complete its review within thirty (30) calendar days of receipt of a second level appeal request and supporting documents. The UMC will communicate its decision to Health Partners' Appeals Coordinator, who will inform the facility in writing of the decision within five (5) business days of the UMC's decision. The decision of the UMC is final; no further right of appeal is provided.

Decision Process for Covering Emerging Medical Technology

Before Health Partners approves new treatments, drugs, or equipment that are still considered experimental, we want to make sure that these new advances are safe and effective. When we receive a provider's request, the request goes through the following processes:

- We request that the provider submit a detailed narrative description of the service or item.
- We check to ensure that existing Federal and State Regulations do not preclude coverage.
- We research available data via online medical resources to obtain more detailed information on the service or item including, but not limited to:
  - FDA approval status
  - Peer-Review Literature
  - Whether the service/item is considered the accepted standard of care in the medical community.

If current clinical reference websites do not have information regarding the requested service or item, Health Partners contacts medical experts directly to obtain pertinent information.

A Health Partners Medical Director reviews the information obtained from current clinical reference guidelines (or medical experts) and determines if the service or item should be covered.

Member Appeals of Denied Services

Members (or their parent/guardian on their behalf) have the right to appeal any decision about payment for, or failure to arrange or continue to arrange for, what they believe are covered services (including non-covered benefits). For more information, see Provider-Initiated Member Appeals (Act 68) on page 10-7 and see Medicaid Member Grievance & Complaint Process on page 11-12.

Out-of-Plan Referrals

Health Partners strongly discourages referrals to non-participating providers. Treatments or services available within the Health Partners network should be performed by a participating provider. Out-of-plan referrals require prior authorization from Health Partners' Inpatient Services or Outpatient Services department. Failure to obtain prior authorization will result in a denial of payment. Health Partners requires a written request documenting the reason(s) the member cannot be treated within the plan's network. While continuity of care is a consideration, it does not automatically result in authorization of these referrals.

In accordance with federal access standards, family planning is an exception from the above requirements for Medical Assistance and CHIP members. Members may be referred, or may self-refer, to any family planning provider, regardless of whether the provider participates with the plan. The right of a Health Partners member to choose a health care provider for family planning services shall not be restricted.

Continuity of Care for New Members

Health Partners is responsible for helping new members transition from another Physical Health Managed Care Organization (PH-MCO) or Fee-for-Service health insurer to our health plan.

Health Partners must coordinate and continue to authorize services under the previous provider reimbursement agreement for up to sixty (60) days, as outlined below. This allows the new member to continue services with a provider outside Health Partners' or KidzPartners' provider network during this transition period only. Health Partners must also send written notification to both the member and the nonparticipating provider, confirming that the member wishes to follow this arrangement.

For new members under age 21

Health Partners must honor the number, length, and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 60 days from the date of enrollment with Health Partners/KidzPartners).

For members 21 and older

Health Partners must honor the number, length and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 60 days from the date of enrollment with Health Partners). However, Health Partners may reduce or terminate services prior to the expiration of this period after concurrent clinical review to determine the need for continued services.

If, as a result of the concurrent clinical review, Health Partners authorizes an alternative course of treatment, a reduction, or termination of another MCO's or the Department of Public Welfare FFS program's approved prior authorization, Health Partners must provide proper written notification of the changes to the member and the prescribing provider and honor the member's right to exercise his/her full grievance and fair hearing rights.

If a new member 21 or older is receiving a course of treatment that did not require prior authorization from the member's previous Medical Assistance Fee-for-Service plan or another PH-MCO, continuation of the service must occur without interruption even if Health Partners would ordinarily require prior authorization for that service. This would apply to the transitional period of up to sixty (60) days from the member's date of enrollment with Health Partners.

In each of the situations outlined above, the 60-day period may be extended if Health Partners' Medical Director finds it to be clinically appropriate.

Pregnant members

If a new (and pregnant) member is already receiving care from an out of network OB-GYN Specialist at the time of enrollment, she may continue to receive services from that specialist throughout the pregnancy and delivery-related postpartum care. This coverage period may also be extended if Health Partners' Medical Director finds it to be clinically appropriate.

Health Partners may recruit the new member's nonparticipating provider to our network, or arrange for the service to be delivered by a participating provider if the enrollee consents to the change.

Per Department of Health regulations, providers must agree to Health Partners' terms and conditions prior to providing service. If the provider does not agree before rendering the service, he/she is required to notify the member of that fact.

Specialist as PCP

A member with a life-threatening degenerative or disabling disease or condition, or a provider or advocate acting on the member's behalf, may request that his/her specialist (with clinical expertise in treating the disease or condition) be allowed to serve as the member's PCP. Health Partners' evaluation of such a request will include a written letter of medical necessity (LOMN) from the specialist and a determination by our Medical Director.

Health Partners' Special Needs Unit (SNU) should be contacted to initiate the request (see Table 1: Service Department Contact Information on page 1-14). The SNU case manager will confirm that both the member and the specialist agree to the request, then will ask that the specialist provide a supporting LOMN. On receipt of the LOMN, the case manager will forward the request to Health Partners' Medical Director, who will have up to 45 days to make a determination.

The case manager will notify the member and specialist of the determination. If approved, the case manager will also initiate credentialing of the specialist as a PCP. Upon satisfactory completion of the credentialing process, the case manager will notify the member and provider that the requested change is complete.

A specialist seeking to serve as PCP must agree to provide or arrange for all primary care, consistent with Health Partners' preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the member's special need and within the scope of the specialist's training and clinical expertise.

Behavioral Health

Behavioral health services include both mental health and substance abuse services

Mental Health Services

Health Partners - Medicaid: For Health Partners members, the Behavioral Health Managed Care Organization (BH-MCO) for the county in which the member lives is responsible for psychiatric care. For more information, see Service Department Contact Information on page 1-14.

KidzPartners- CHIP: CompCare is Health Partners' behavioral health subcontractor for our KidzPartners program. All services other than emergency services must be prior authorized by CompCare. Prior authorization can be obtained by calling CompCare (see Table 1: Service Department Contact Information on page 1-14).

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

- Bucks County Magellan Behavioral Health 1-877-769-9784
- Chester County Community Care Behavioral Health 1-866-622-4228
- Delaware County Magellan Behavioral Health 1-888-207-2911
- Montgomery County Magellan Behavioral Health 1-877-769-9782
- Philadelphia County Community Behavioral Health 1-888-545-2600

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 mental health and drug and alcohol .
- 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 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, the following:

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

- EPSDT behavioral health rehabilitation services for Members up to age 21

Health Care Providers may call Special Needs Unit Department at **215-967-4690** whenever they need help referring a member for behavioral health services.

Substance Abuse Treatment

Health Partners - Medicaid: For Health Partners members, the HealthChoices Behavioral Health Managed Care Organization (BH-MCO) for the county in which the member lives is responsible for substance abuse services.

KidzPartners- CHIP: CompCare is Health Partners' behavioral health subcontractor for our KidzPartners program. Substance abuse services may be accessed by calling **877-710-8222**. All services must be prior authorized. CompCare must be contacted within 24 hours of an emergency admission.

Coordination with Behavioral Health

Health Partners - Medicaid: The Special Needs Unit (SNU) Case Managers can collaborate with the appropriate Behavioral Health Managed Care Organization (BH-MCO) to coordinate psychiatric services and/or drug and alcohol treatment for any Health Partners member. A case manager will assist members interested in treatment by coordinating conference calls with the appropriate providers to ensure that the referral is completed.

In addition, the SNU assists members with transportation to either behavioral or physical medical appointments by helping them complete application to the Medical Assistance Transportation Program (MATP). MATP coordinates rides to and from these appointments for Medical Assistance recipients. MATP offices are located in Chester, Bucks, Delaware, Montgomery, and Philadelphia counties.

Contact the Special Needs Unit (see Table 1: Service Department Contact Information on page 1-14).

KidzPartners- CHIP: Behavioral health services are covered benefits in the KidzPartners program. SNU Case Managers are available to help KidzPartners members with any special coordination needs.

Anti-Gag Policy

The provider may freely communicate with each member regarding the treatment options available to him/her, including information regarding the nature of treatment, alternative treatment, risks of alternative treatments, or the availability of alternative therapies, consultation, or tests, regardless of benefit coverage limitations. The provider is expected to educate patients regarding their health needs; share findings of the member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms without regard to plan coverage; and recognize that the member has the final say in the course of action to take among clinically acceptable choices. No provision of this Manual or the Participating Provider Agreement shall prohibit open clinical dialogue between the provider and members.

Health Partners' goal is to ensure that all members receive the most appropriate medical care available. Health Partners does not directly or indirectly reward physicians, providers, contracted entities, employees, or any other individuals participating in utilization review decisions for denying or limiting coverage or service. Health Partners also does not provide financial incentives for utilization management decision makers that result in the under-utilization of care or service.

While Health Partners may utilize incentives to foster efficient, appropriate care, it does not employ incentives to encourage barriers to care and service. It is therefore expected that all contracted and delegated physicians and

providers as well as employees who deal with utilization review activities make utilization determinations regarding benefits covered by Health Partners based only upon the appropriate use of care and services for the member.