Health Partners Essential

PROVIDER TRAINING

FALL 2014

Members Rights

Health Partners Essential members, have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way you are treated by Health Partners Plans, its participating providers or other State agencies.

Policies surrounding Members Rights can be found in the Provider Manual (Appendix Chapter 14 -6).

Respect of Conscience Rights

Health Partners Essential respects the conscience rights of individual providers and provider organizations, as long as these conscience rights are made known to Health Partners Plans in advance, and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to provide health care services on moral or religious grounds.

If the provider elects to invoke conscience rights, Health Partners Plans would expect for the provider to contact the Utilization Management department to arrange for alternative care for the member. Utilization Management will work with Network Management to identify an alternative provider who can offer the care to the member.

Health Partners Essential provides for both physical and behavioral health benefits. The full description of those benefits can be found in our provider manual in the Health Partners Essential Benefits section.

Health Partners Essential and Network Providers will cover health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice in accordance with "medically necessary services."

Health Partners Essential will pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered services for qualified Medicare beneficiaries and In/Out - of - Network Providers; will not deny or reduce the amount, durations or scope of services due to a Member's diagnosis, type of illness or condition.

Health Partners Essential, subcontractors and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance.

Health Partners Essential will ensure that a Member who is eligible for both (Healthy PA and Medicare benefits) can access services from the Medicare provider of their choice.

Emergency Services

Health Partners Essential 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 Public 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, in respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; serious impairment to bodily function; or serious dysfunction of any bodily organ or part.

Nursing Facility Care

Health Partners Plans is responsible for up to 120 days of nursing facility care (including hospital reserve and/or bed hold days). The days need not be consecutive.

Copayments

Providers will collect copayments at time of service.

Information regarding copayments is identified in MA Bulletin 99-12-03, entitled, Updates to Medical Assistance Copayment Policy, which may be viewed online at:

- http://www.dpw.state.pa.us/publications/bulletinsearch/bulletinselected/index.htm?bn=99-12-03&o=N&po=OMAP&id=04/16/2012.

Copayments for services are summarized in the benefits section of the Provider Manual.

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) the Health Partners Member Relations department (see **Table 1: Service Department Contact Information** on **page 1-15**).

Abortions

Abortions are covered in cases of rape, incest, or when the life of the Member is in danger. A Federal Certification (MA-3) form must be completed by the provider and submitted with the claim in order for payment.

Prior Authorization Process

A quick reference chart that list many Health Partners Essential benefits and services can be found in the Provider Manual under Health Partners Essential Benefits Section 7.4

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

Referral

Health Partners Plans no longer provides or utilizes a referral form. A referral can be issued on an individual PCP's prescription pad.

When it is determined by the PCP that a member needs specialist services, the PCP must issue a prescription to a specialist or facility within the Health Partners Plans network. The prescription may be given to the member to take to the participating specialist or facility, or may be faxed to the provider prior to the member's appointment.

PCP 's must follow the steps below before directing a member to another participating provider:

- The prescription is valid for 90 days only.
- A PCP is not restricted regarding the specialist treatment criteria (i.e. length of time the member sees the specialist or the number of visits that are ordered).
- If a specialist does not participate with Health Partners Plans, prior authorization must be requested.

Possession of a prescription from a participating PCP does not guarantee payment. The prescription does not need to be submitted with a claim.

If a member is not eligible with Health Partners Plans on the date of service, the physician will not be paid. To be sure, log on to HP Connect at *www.HealthPartnersPlans.com* or call Health Partners Plans.

Practice Guidelines

Health Partners Plans will adopt, disseminate and apply practice guidelines consistent with 42 C. F. R. subsection 438.236.

Prior Authorization of Prescription Drugs

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 request a prior authorization the physician or a member of his/her staff should contact Health Partners Plans. 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 Member Services at **1-855-215-7077 (TTY 711)**. The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

Whenever the Health Partners Plans Pharmacy department is unavailable for consultation or prior authorization for a new medication, an automated five (5) day supply of medication (if FDA approved) can be dispensed at the point of sale at the discretion of the dispensing pharmacist.

Additional information can be found in the Provider Manual under Health Partners Essential Benefits Section 7.17.

Continuity of Care

Health Partners Plans must coordinate and continue to authorize services under the previous provider reimbursement agreement for up to ninety (90) days if necessary, as outlined below. This allows the new member to continue services with a provider outside of Health Partners Plans provider network during this transition period only. Health Partners Plans must also send written notification to both the member and the nonparticipating provider, confirming that the member wishes to follow this arrangement.

Coordination of Care

Health Partners Essential will provide seamless and continuous coordination of care across a continuum of services for members with a focus on improving health care outcomes. Members health care needs will be assessed to identify member specific goals and work to eliminate barriers. To the extent possible and appropriate, members will be allowed to select his or her health care professional.

The Special Needs Unit (SNU) serves as a critical link between members and doctors. SNU will assess members with special needs as defined by the Department to identify ongoing special conditions requiring treatment or monitoring. If determined necessary, Health Partners Plans and the treating provider are responsible for the development of a treatment plan in accordance with the requirements of 42 CFR subsection 438.208(c) and 28 PA code subsection 9.68(3).

Member Incentive and Encouraging Employment

Throughout the year, Health Partners Plans has incentives programs related to improving member health outcomes along with educational presentations that could assist employment opportunities.

These programs and presentations are approved by DPW and communications are sent to providers and members regarding these opportunities.

Newborn Coverage

Newborns are eligible for Health Partners Plans benefits if the mother is enrolled at the time of the child's birth. Until the newborn is assigned a permanent Medicaid recipient number by DPW, authorizations will be set-up under a temporary ID. The temporary ID is usually the baby's mother's ID ending with Z and a sequential number at the end. A permanent ID can be assigned as early as ten days after the date of birth. The newborn's ID, whether temporary or permanent, can be confirmed through Provider Services at **215-991-4350** or **888-991-9023**.

Health Partners Essential is not responsible for:

- Physician services provided for the newborn
- An inpatient claim other than a Normal Newborn stay
- An inpatient claim for a complex newborn
- A metabolic screening
- Any medical product or service other than an inpatient Normal Newborn stay.

Advance Directives

Advance Directives are written documents designed to allow competent patients the opportunity to guide future health care decisions in the event that they are unable to participate directly in medical decision making.

Providers must note the presence of an advance directive in the member's medical record, and follow all applicable state and federal laws regarding the execution of these directives.

Member Liability

Health Partners Essential is prohibited from holding a Member liable for the following:

- Debts of Health Partners Essential in the event of insolvency
- Services provided to the Member in the event of Health Partners Essential failing to receive payment from the Department for such services.
- Services provided to the Member in the event of a Health Care Provider with a contractual, referral or other arrangement with Health Partners Essential failing to receive payment from the Department or Health Partners Essential for such services.
- Payments to a Provider that furnish compensable services under a contractual, referral or other arrangement with Health Partners Essential in excess of the amount that would be owed by the Member if Health Partners Essential had directly provided the services.

Emergency Services

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 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.

Additional information can be found in the Provider Manual Section 7-11.

Non-emergent use of the emergency room is not a covered beneft.