6. COVERAGE GUIDELINES

Prior Authorization

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

- All non-emergency services performed by non-KidzPartners participating providers
- All scheduled (non-emergency) hospital admissions
- Ambulance services (non-emergency)
- Ambulatory Surgical Center/Short Procedure Unit procedures
- Certain durable medical equipment, such as wheelchairs and repairs
- Chemotherapy
- CT scans/PET scans/MRI
- Echocardiography
- Medicines not included in the KidzPartners formulary
- Occupational/Physical/Speech Therapy
- Other services as indicated on the "KidzPartners Benefits" chart in Section 5

When Health Partners Plans receives a complete request for prior authorization, we will contact you by phone within two business days from the date we received the request to tell you if we approved the service or item requested. A written decision notice will be mailed to you within two business days from the date of our decision.

If Health Partners Plans believes that we do not have all the information needed to make a decision, we will ask for the additional information needed from your children's provider within 48 hours of when we get the request. Health Partners Plans will let you know that we asked your provider for this additional information.

Health Partners Plans will contact you by phone and in writing with our decision within two business days after we get the additional information from your provider.

If your provider does not send the additional information within 14 calendar days of our request, then we will base our decision on the information available, will send you a written notice of our decision and will contact you verbally within two business days.

You have the right to appeal any prior authorization request that is denied. The written notice will tell you what you have to do to appeal.

Health Partners Plans follows set standards when making a decision about prior authorization or whether a procedure is medically necessary. These standards are called clinical criteria. Your provider can get a copy of these criteria by calling the provider helpline.

You may get a copy of the clinical criteria used in making a medical necessity decision by calling Member Relations at 1-888-888-1211 (TTY 711).

If your children's provider calls for an authorization for a service and it is not approved, Health Partners Plans will not pay for that service. However, you may still receive the service if you are willing to pay out of pocket. Your provider will have you sign a form saying you are aware you are responsible for paying for this unauthorized service.

Before your children receive any service requiring prior authorization, you have the right to check that authorization has been approved by calling Member Relations at 1-888-888-1211 (TTY 711).

Payment Denials

When Health Partners Plans denies payment to a provider after your children have already received the service, we will send you a notice that tells you that payment was denied for one of the following reasons:

- The service(s)/item(s) were provided without prior authorization.
- The service(s)/item(s) were not a KidzPartners covered benefit.
- The admission or service was not medically necessary.

The purpose of these notices is to tell you of our decision to deny payment and to tell you whether the provider may or may not bill you for those services.

Before your children receive any service requiring prior authorization, you have the right to check that authorization has been approved by calling Member Relations at 1-888-888-1211 (TTY 711).

Medical Necessity

In determining whether health care services for KidzPartners members are medically necessary and appropriate, Health Partners Plans considers the Pennsylvania Insurance Department definition as its standard. Satisfaction of this standard will result in coverage of the care or service, which is subject to benefit limitations.

Medically necessary and appropriate is defined as 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:

1. In accordance with generally accepted standards of medical practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. 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.

How We Cover New Services for KidzPartners Members

New advances in medicine can help us stay healthy. Before Health Partners Plans approves a new service or item, we want to make sure that these new advances are safe and helpful. That's why we are careful when we decide if we should cover a new service or item. Here's how we make our decision:

1. We receive a provider's request for a service or item.
2. We ask the provider to give us a letter that tells us all the details about the service or item and that also explains why the member needs the service or item.
3. We perform a web-based literature search to find out more details about the service or item. These details could include:
   - Whether the service or item was approved by the Food and Drug Administration;
   - If other providers have used the service or item and wrote about how it worked for them;
   - Whether the service or item is accepted as useful by other providers. If a literature search does not yield relevant information about the service or item, we contact medical experts directly to get details about the service or item.
4. After the details of the service or item are provided to us from either the literature search or the medical expert, one of our Medical Directors will review the details about the experimental service or item. After review, the Health Partners Plans Medical Director makes a decision about whether the service or item should be covered.

These steps help ensure that the service or item is both safe and helpful for your children. Experimental services or procedures are not covered under KidzPartners.

If You Move or Change Your Phone Number

If you move or change your phone number, please notify us right away by calling KidzPartners Member Relations at 1-888-888-1211 (TTY 711). This is important so that we can provide your children's health care coverage smoothly. This is a KidzPartners member is responsibility.

As long as you move to an area within Bucks, Chester, Delaware, Montgomery or Philadelphia counties, your children can remain enrolled with KidzPartners. If you move outside the five-county area of Southeastern Pennsylvania, you will need to select a different CHIP provider.

Family Size Changes

If your family size changes, call KidzPartners Member Relations at 1-888-888-1211 (TTY 711).

Note: CHIP coverage will be extended to babies born to CHIP members for 31 days. It is important to apply for Medical Assistance or CHIP right away to provide continued coverage for the baby. Only one application needs to be completed to apply for both programs.