



Chapter 4

Health Partners (Medicaid) Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to Health Partners (Medicaid) members

Topics: Important topics from this chapter include:

- Summary of Medicaid benefits

Overview

This chapter provides an overview of the benefits Health Partners (Medicaid) 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 (Medicaid) 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 Medicaid benefits and services. It indicates whether an authorization 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, maternity care, family planning services and renal dialysis services. Pregnant members already receiving care from an Out-of-Network practitioner at the time of enrollment may continue to receive services from that specialist throughout the pregnancy and postpartum period related to the delivery.

Health Partners (Medicaid) Benefits

The following table list the benefits available to Health Partners (Medicaid) members and any prior authorization, cost sharing, or benefit limit requirements associated with those services.

| Table 4A: Health Partners (Medicaid) Benefits | | | | |
|---|---------|----------------|----------------------|-------|
| Benefit / Service | Covered | Benefit Limit | Prior Authorization | Copay |
| Acupuncture | Yes | 20 visits/year | No | \$5 |
| Advanced Diagnostic Radiology (MRI, CT, PET) | Yes | No | Yes: Contact eviCore | \$1 |
| Ambulance (Emergent) | Yes | No | No | \$0 |
| Ambulatory Surgery Center/ Short Procedure Unit | Yes | No | No | \$3 |
| Annual Eye Exam | Yes | 2/year | No | \$0 |

| Table 4A: Health Partners (Medicaid) Benefits | | | | |
|--|----------------|---|-------------------------------|--------------------------------------|
| Benefit / Service | Covered | Benefit Limit | Prior Authorization | Copay |
| Audiology Services | Yes | No | No | \$0 |
| Chiropractic Services | Yes | No | Yes: Contact eviCore | \$1 |
| Clinic (Outpatient Hospital, Independent, & FQHC) | Yes | No | No | \$0 |
| Cosmetic Services | No | N/A | Yes: For Restorative Services | \$0 |
| Cardiac Rhythm Devices (Pacers and Defibrillators) | Yes | No | Yes: Contact eviCore | \$0 |
| Dental (Diagnostic, preventive, restorative and surgical dental procedures, prosthodontics and sedation.) | Yes | Dentures 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns, Periodontics and Endodontics only via approved benefit limit exception | Contact Avesis | \$0 |
| Diagnostic cardiac catheterizations | Yes | No | Yes: Contact eviCore | \$0 |
| Diagnostic Radiology (X-ray) | Yes | No | No | \$1 |
| Durable Medical Equipment Purchase > \$500 | Yes | No | Yes | \$0 |
| Durable Medical Equipment Rental | Yes | No | Yes | \$0 |
| Elective Inpatient Surgical Care | Yes | No | Yes | \$3 per day up to \$21 per admission |
| Emergency Services | Yes | No | No | \$0 |
| Eyewear (Contact, Lenses, or Frames) | Yes | Limited to individuals with aphakia and | Yes (contact Davis Vision) | \$0 |

| Table 4A: Health Partners (Medicaid) Benefits | | | | |
|---|----------------|---|----------------------------|--------------------------------------|
| Benefit / Service | Covered | Benefit Limit | Prior Authorization | Copay |
| | | cataracts 4 lenses/year 4 contact/year 2 frames/year | | |
| Family Planning | Yes | No | No | \$0 |
| Fitness (Gym) Membership | Yes | Annual membership covered. Program requirements apply | No | \$2 probationary visits |
| Hearing Aids | No | N/A | N/A | N/A |
| Home Infusion | Yes | No | Yes | \$0 |
| Home Health Nurses, Social Workers, Aids or Therapists | Yes | No | Yes | \$0 |
| Hospice (Inpatient only) | Yes | No | Yes: LOMN & COTI | \$0 |
| Hyperbaric Oxygen Therapy | Yes | No | Yes | \$0 |
| Infertility Treatment | No | N/A | N/A | N/A |
| Inpatient Acute Hospital | Yes | No | Yes | \$3 per day up to \$21 per admission |
| Inpatient Rehab Hospital | Yes | 1 admission/year | Yes | \$3 per day up to \$21 per admission |
| Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (IID) and Other Related Conditions (ORC) | Yes | ICF/IID Admission results in immediate disenrollment; ICF/ORC admission requires prior auth. 30 days with disenrollment. | Yes | \$0 |
| Laboratory | Yes | No | No: Must use capitated lab | \$0 |
| Long Term/Custodial Nursing Home Care | Yes | No | Yes | \$0 |

| Table 4A: Health Partners (Medicaid) Benefits | | | | |
|--|---|----------------------|--|---------------------------|
| Benefit / Service | Covered | Benefit Limit | Prior Authorization | Copay |
| Medical Diagnostics | Yes | No | No | \$1 |
| Medical Oncology (Chemotherapy) | Yes | No | Yes: Contact /eviCore | \$0 |
| Medical/Surgical Supplies | Yes: Diabetic supplies are covered under the RX benefit | No | Yes: >\$500 | \$0 |
| Non-Emergent Care Outside USA | No | N/A | N/A | N/A |
| Non-Emergent Ambulance | Yes | No | Yes | \$0 |
| Nuclear Medicine | Yes | No | No | \$1 |
| Nutritional Supplements | Yes | No | Yes | \$0 |
| Obstetrical – Outpatient (Pre and Post-Natal) | Yes | No | No | \$0 |
| Orthotic (Diabetics only) | Yes | No | Yes | \$0 |
| Outpatient Physical and Occupational Therapy | Yes | No | Yes: Contact eviCore | \$0 |
| Outpatient Speech Therapy | Yes | No | Yes: Contact eviCore | \$0 |
| PCP visits (including CRNP, PA) | Yes | No | No | \$0 |
| Pain Management | Yes | No | Yes: Contact eviCore | \$0 |
| Pharmaceutical | Yes | No | Yes: If designated as prior authorization drug or non-formulary (Prescription) | \$1 generic and \$3 brand |
| Podiatrist Services | Yes | No | No | \$0 |
| Preventative Physical exam | Yes | No | No | \$0 |
| Private Duty Nursing | No | N/A | N/A | N/A |

| Table 4A: Health Partners (Medicaid) Benefits | | | | |
|--|----------------|---|----------------------------|--------------|
| Benefit / Service | Covered | Benefit Limit | Prior Authorization | Copay |
| Prosthetic Device | Yes | Hearing Aids are not covered. Ocular prosthesis is limited to 1/yr. Low vision aids are limited to 1/2yr. | Yes | \$0 |
| Radiation Therapy | Yes | No | Yes: Contact eviCore | \$0 |
| Renal Dialysis | Yes | No | No | \$0 |
| Respite Care | Yes | 5 days every 60 certified days | Yes | \$0 |
| Skilled Nursing Facility | Yes | No | Yes | \$0 |
| Sleep Studies | Yes | No | Yes: Contact eviCore | \$1 |
| Specialist visits (including CRNP, PA) | Yes | No | No | \$0 |
| Spine and Joint Surgeries | Yes | No | Yes: Contact eviCore | \$0 |
| Stress Echocardiography, Echocardiography, & Cardiac Nuclear Medicine Imaging | Yes | No | Yes: Contact eviCore | \$1 |
| Tobacco Cessation | Yes | 70 visits per calendar year | No | \$0 |
| Transportation (van service) | Yes | No | Yes | \$0 |
| Ultrasound (US) | Yes | No | No | \$1 |
| Urgent Care | Yes | No | No | \$0 |
| Vascular Surgeries | Yes | No | Yes | \$0 |

Benefits During and After Pregnancy

Members who are confirmed to be pregnant are not subject to limitations on the number of services or copayments. 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 the end of their postpartum care. These services include expanded nutritional counseling and smoking cessation services. However, services not ordinarily covered under a pregnant member's benefit package are 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.

Pregnant members have no service limitations

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

Health Partners (Medicaid) members with Medicare coverage

For members with Medicare coverage, 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 above have been reached, the service will be denied.

For example: A Health Partners member has had one inpatient rehab admission and Medicare denies the second inpatient rehab admission. Since that rehab admission exceeds the one per year Medicaid limit, Health Partners will deny the claim. If Medicare pays the second admission, Health Partners will pay the co-insurance or deductible up to the amount Health Partners would have paid had Health Partners been primary.

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 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, an 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.

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.

Allergy Testing and Treatment

The Primary Care Physician (PCP) is responsible for coordinating the treatment of allergies. 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. Allergist should use Procedure Code 95165 for preparation of serum.

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).

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. 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

Cardiac rehabilitation services are covered when the member has 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. Contact eviCore Inc., for prior authorization.

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.

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 procedures that require hospitalization must be prior authorized by Health Partners Plans' Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.

Members can receive dental services from a participating primary care dentist. All they have to do is choose a dentist from the list of dentists in the online Provider Directory. The primary care dentist will coordinate members to periodontists and other dental specialists according to the policies defined by the dental subcontractor and approved by Health Partners Plans.

Diabetes Self-Management Training and Education

Outpatient Diabetes Self-Management Training and Education services furnished to an individual with diabetes are covered 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. For more information, refer to the [Contact Information](#) section starting on page 1.13.

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. Please refer to the formulary located on our website for more information.

Dialysis

Hemodialysis and peritoneal dialysis are covered benefits. Members requiring these services should be directed to a participating specialist. In cases where the HPP Medicaid member also has Medicare coverage, Health Partners becomes secondary insurance. Dialysis services do not need prior authorization.

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 and outpatient services less than \$500 per claim line DO NOT require prior authorization from Health Partners Plans.
- 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 DME rentals require prior authorization, regardless of reimbursement value.
- When the patient is renting a DME product covered by their previous insurer, it is the DME provider's responsibility to provide Health Partners Plans with the following information:
 - Clinical documentation
 - Physician orders
 - Number of months covered by the previous insurer
 - Termination date of the member's previous insurance coverage

If, at time of the member's transition, the DME rental is deemed medically necessary, Health Partners Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (60 days) to ensure continuity of care.

- All special items which do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Over 200 diapers/month requires prior authorization.
- Authorizations are based on benefit coverage/medical necessity.

- Preferred nebulizers and humidifiers are covered under the pharmacy benefit.

If you have questions, please call the Health Partners Plans 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 Medical Management (refer to the [Contact Information](#) section starting on page 1.13) and leave a message, which will be forwarded to an on-call nurse case manager. See the Utilization Management chapter (Chapter 7) for contact information.

Emergency Care

Emergency care and post-stabilization services 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. Members are not responsible for any payments. Emergency care and post-stabilization services do not require prior authorization.

Non-par follow-up specialty care for an emergency is covered by Health Partners, but our staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible. Members are 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 Human Services 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.

Family Planning

Family planning counseling services are covered by Health Partners Plans. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist, nurse midwife or a Family Planning Council site. Members have the option to self-refer to the Family Planning Council, Ob/Gyn or nurse midwife without prior approval from a PCP. 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 Plans Member Relations department. For more information, refer to the [Contact Information](#) section starting on page 1.13.

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. No prior authorization is needed.

Gynecological and/or Obstetric Examinations

The PCP may perform routine gynecological exams as appropriate. Members may self-refer to OB/GYN specialists or nurse midwives for any routine gynecological and/or maternity services without prior approval from a PCP. Members receiving maternity care from an Out-of-Network OB/GYN at the time of enrollment may continue to receive services from that provider throughout the pregnancy and postpartum period.

- Providers are encouraged to notify Health Partners Plans as soon as a pregnant member is identified. Providers can call the Baby Partners hotline 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 Plans' care coordination team.
- Pennsylvania's Medical Assistance Program (Medicaid) requires all Obstetrical Needs Assessment Forms (ONAFs) to be submitted electronically online via eviCore Optum's portal at obcare.optum.com.

For more information, refer to the [Contact Information](#) section starting on page 1.13.

Healthy Kids

The Early, and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit 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 promote early detection and, as applicable, treatment of conditions and illnesses affecting growth and development in the Medical Assistance population. Services include physical examinations, blood lead testing and treatment, 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 Plans' Pediatric and Adolescent Preventive Care Flow Sheets, Screening Schedule, and Pediatric Immunization Schedule are designed to assist PCPs in delivering EPSDT-related services. The EPSDT Periodicity Schedule is located on the Health Partners Plan website for easy reference and is available upon request by contacting the HPP Provider Services Helpline at **1-888-991-9023** or **215-991-4350**. PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by Health Partners Plans. 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 Plans' Healthy Kids department for further information. For more information, refer to the [Contact Information](#) section starting on page 1.13.

Providers are paid an additional administrative fee of \$20 for each EPSDT screen that includes an EP modifier for select Evaluation & Management (E&M) codes (certain contractual exceptions may apply).

Hearing Examinations

Audiometry/tympanometry is covered for children up to age 21.

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.

One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 21-56 days post-delivery. Additional post-delivery home care visits will require prior authorization.

Hospice Care

Health Partners Plans 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 healthcare 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. For more information, see the [Contact Information](#) section starting on page 1.13.

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, 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 Plans' 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 Plans approves, in advance, a stay in a hospital that does not participate with us.

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 (DME) 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 corneal transplants for approved indications in Medicare-certified transplant facilities or transplant facilities approved by Health Partners Plans
- 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 and alcohol and drug abuse services and are managed by the Behavioral Health Managed Care Organization (BH-MCO).

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 Plans 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 <http://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 through the Pennsylvania Statewide Immunization System at www.health.pa.gov/MyRecords/Registries/PA%20SIIS/Pages/default.aspx#.WdPwDRjD-70 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 chapter. Please refer to the formulary located at www.hpplans.com/formulary for more information regarding specific coverage such as prior authorization, for specialty medications.

Laboratory

Outpatient laboratory services are provided through Quest Diagnostics. Locations of participating labs can be found via our online provider directory at www.hpplans.com/provdirectory. 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 authorization is needed if the provider is in the Health Partners network.

Medical Oncology Services

Medical oncology services are covered. Inpatient services require prior authorization by Health Partners Plans. Contact eviCore Inc., for prior authorization.

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 HCPCS 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 and skilled nursing facility or at home, by a Health Partners participating physician/provider, are covered.

Mental Health and Substance Abuse Treatment

Under HealthChoices, all Medical Assistance members, regardless of the health plan/MCO to which they belong, receive mental health and substance abuse treatment through the behavioral health managed care organization (BH-MCO) assigned to their county of residence. For more information, see the [Behavioral Health](#) contact information on page 1.13.

PCPs who identify a Health Partners member in need of behavioral health services should direct the member to call his or her county's BH-MCO. The BH-MCO will conduct an intake assessment and refer the member to the appropriate level of care.

Nebulizer Treatment

PCPs are reimbursed fees above capitation (if applicable) 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. Non-self-administered drugs in the outpatient setting — not covered under the pharmacy benefit — are available through the contractual buy and bill process based on Health Partners Plans medical fee schedule.

The formulary and prior authorization processes are key components of the benefit design. Health Partners Plans, through its Pharmacy department, provides prescription benefits for our members with the use of a closed formulary. The formulary covers many brand and generic drugs, with exceptions such as 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), manufacturers who do not participate in the Federal Rebate program, 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 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 Plans Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Health Partners Plans 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 as well as drug specific prior authorization forms are posted on our website at www.hpplans.com/formulary.

For additional printed copies, please call the Provider Services Helpline. For more information, refer to the [Contact Information](#) section starting on page 1.13.

Pharmacy Benefit Design

A maximum of a 30-day supply of medication is eligible for coverage in an outpatient setting. Refills can be obtained when 80% of utilization has occurred. The prescriber is urged to prescribe in amounts that adhere to FDA guidelines and accepted standards of care.

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

The copayments for prescription drugs are as follows:

- \$1.00 for generic prescription drugs.
- \$3.00 for brand prescription drugs.
- 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 over-the-counter (OTC) medications. Certain OTC drugs (e.g. aspirin, acetaminophen, vitamins, , hydrocortisone) 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. Preferred diabetic supplies can be found on the formulary located at www.hpplans.com/formulary. The OTC products listed in the formulary are covered with a written prescription.

Certain vaccines (such as flu, pneumonia, hepatitis and varicella zoster) are covered under the pharmacy benefit with a prescription for members 19 and older. Please refer to the Vaccines for Children (VFC) program regarding coverage of vaccines for members 0 to 18 years of age. Please refer to the formulary for more information regarding which vaccines are covered at the point of sale pharmacy. Members are encouraged to go to a participating network pharmacy which can supply and administer the vaccine.

Pharmacy Prior Authorization

There are specific medications on the formulary that require prior authorization. Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on the website at www.hppplans.com/priorauth. There may be occasions when an unlisted drug or non-formulary is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through a medical exception process using the Non-formulary Prior Authorization form.

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 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
- Drugs that exceed FDA prescribing limits

To request a prior authorization, the physician or a member of his/her staff should contact Health Partners Plans' Pharmacy department at **215-991-4300** or toll free at **1-866-841-7659**. All requests can be faxed (**1-866-240-3712**) 24 hours per day; calls should be placed from 8:00 A.M. to 6:00 P.M., Monday through Friday. In the event of an immediate need after business hours, the call should be made to Member Relations at **1-800-553-0784** or **215-849-9600**. The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

The physician may use Health Partners Plans' drug specific forms or a letter of request, but must include the following information for a quick and appropriate review to take place:

- Specific reason for request
- Name and recipient number of member
- Date of birthdate of member
- Physician's name, license number, NPI number and specialty
- Physician's phone and fax numbers
- Name of primary care physician (PCP) 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 and documentation such as pharmacy records or chart notes
- Additional clinical information that may contribute to the review decision such as specific lab results.

All forms should be legible and completely filled out. All prior authorization forms are available on the Health Partners Plans website at www.hpplans.com/priorauth..

Upon receiving the prior authorization request from the prescriber, Health Partners Plans 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 letter will also be faxed or mailed to the prescribing physician. At any time 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 at **215-991-4300**.

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

- 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 Plans will allow the pharmacy to dispense a five (5) day supply* of the medication to ensure that the member receives the prescribed medication while the recipient or pharmacy takes the appropriate steps to complete the prior authorization process in a timely manner.

- 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 Plans will allow the pharmacy to dispense a 15-day supply* of the medication automatically, unless Health Partners Plans 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.

* Note: The DHS requirement that the Member be given at least a seventy-two (72) hour supply (Health Partners Plans allows for five days) for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication — either alone or along with other medication that the Member may be taking — would jeopardize the health or safety of the Member.

Health Partners Plans 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 member.

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

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

Members have coverage for outpatient PT/OT/ST when performed by a participating Health Partners provider. Contact eviCore for prior authorization, which is required for all outpatient PT/OT/ST. Prior authorization is not required for outpatient evaluation. Contact eviCore Inc., for prior authorization.

Preventive Health Services

Preventive health services, including routine physical exams, health screening, health education and well child care, are covered according to schedules approved by Health Partners Plans, 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 Plans' Outpatient Services department. Orthotics and customized devices require prior authorization.

Radiation Therapy

Radiation therapy services are covered. Contact eviCore Inc., for prior authorization for radiation therapy.

Rehabilitation

Please see alphabetized listings "Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)." Inpatient rehabilitation requires a prior authorization.

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 Plans' Inpatient Services department.

Smoking Cessation

Various smoking cessation services are available to our members to assist them in quitting smoking. Please reference our website for the most current reimbursable expenses.

Specialist Visits

PCP referrals to Health Partners participating specialists and other providers are *not* required. Services provided by non-Health Partners participating physicians and other non-participating licensed allied health personnel will be covered only when prior authorized by Health Partners Plans.

While PCP referrals are *not* required, we still consider the Primary Care Physician (PCP) to be the gatekeeper of care. When coordinating care, the PCP should continue to direct the member to a specialist who the PCP believes can best assist with the care needed. In return, it is extremely

important for specialists to continue to keep a patient's assigned PCP informed of all care they render to the patient. This ensures that the PCP has the appropriate opportunity to manage the overall health of the patient as care is provided, and that the patient, our member, benefits from the robust coordination of care.

Specialty Medication Program

Health Partners Plans supports appropriate use of specialty medications and has established suppliers as well as procedures for appropriate prescribing and monitoring. Under the direction of the Health Partners Plans' 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 to the Health Partners Plans Pharmacy department by fax with all pertinent lab information at **1-866-240-3712**.

Specialty medications are higher cost, biologics, injections or oral medications that require special handling, monitoring, or have limited distribution per manufacturer or FDA guidelines. Specific specialty pharmacy vendors who have met high quality measures and accreditation are contracted with Health Partners Plans to handle and distribute these medications.

All requests for prior authorization are reviewed by the Pharmacy department for approval. Approvals, including approvals for shorter durations are coordinated with the contracted specialty vendor for distribution to the provider's office or member's home.

In addition, the prescriber can always call Health Partners Plans' Pharmacy department at **215-991-4300** for assistance with the prior authorization on specialty medications and preferred specialty vendors. Specific prior authorization forms are available on the Health Partners Plans website at www.hpplans.com/priorauth.

Certain medications, including the following, can be obtained through the retail pharmacy benefit without prior authorization.

- diphenhydramine
- Insulin
- epinephrine (bee sting kits)
- vitamin B-12
- heparin
- ceftriaxone

- triamcinolone
- methylprednisolone
- haloperidol decanoate
- fluphenazine decanoate
- Glucagon Emergency Kit
- Penicillin G

Certain specialty medications are processed through the Pharmacy department and require a prior authorization. Please refer to the formulary and the website for more information regarding specialty medications, drug specific prior authorization forms, and preferred vendors. For further information visit our specialty page <https://www.healthpartnersplans.com/members/health-partners/resources/prescription-drug-information/specialty-medications-and-pharmacies>.

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.

Transportation (Non-Emergent)

Non-emergent transportation services require prior authorization.

Health Partners members are eligible for registration with the DHS Medical Assistance Transportation Program (MATP – more info available at <http://matp.pa.gov/>). 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, refer to the [Contact Information](#) section starting on page 1.13.

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 through the Philadelphia VFC program at <http://www.health.state.pa.us/vfc> or call **1-888-646-6864**. 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.

Providers outside Philadelphia County should obtain their vaccine from the state VFC program by calling **215-685-6498** or visiting the website for the PA Department of Immunizations at <http://www.health.pa.gov/>.

Vision Care

Health Partners covers vision care for all members through our subcontracted provider, Davis Vision. Members can choose a vision care provider from the online Health Partners Provider Directory.

Davis Vision covers routine eye examinations for all members.

For members under 21, EPSDT services are covered as medically necessary. Children are eligible for eyeglasses and contact lenses when medically necessary.

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

- For members diagnosed with aphakia (where the eye lens is missing as a result of congenital defect, trauma, or surgery), two prescription eyeglass lenses, two frames, and four prescription contact lenses are covered yearly.

Replacement eyeglasses or contacts for members with 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 online provider directory or call Member Relations for a printed list of providers or other help.

Value Added Benefits

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 prior authorization is required. Members can self-refer.

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

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. No prior authorization is required. There is no annual visit limit; however, there is a \$2 copay for each probationary visit that needs to be completed in the first 90 days of enrollment. Children have no co-pay and must complete 6 visits in that timeframe.

Non-Covered Services

The following services and benefits are excluded or limited under the Health Partners plan. Members may self-refer themselves for these services at their own expense.

- 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 Plans
- 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 chapter.

Medical Directors will not approve services that are deemed harmful to our members, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on The Centers for Medicare and Medicaid Services (CMS) guidelines, 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.

Recipient Restriction Program

Health Partners participates in the Pennsylvania Department of Human Services Recipient Restriction Program. The program calls for Health Partners to monitor and identify Medical Assistance recipients who improperly or excessively utilize Medicaid services. In cooperation with the Department of Human Services' Bureau of Program Integrity, Health Partners will refer members with suspected patterns of inappropriate utilization to the Pennsylvania Department of Human Services' Recipient Restriction Program. These members may be restricted to a certain physician and/or pharmacy. Providers requesting information on this program may contact the Health Partners Pharmacy department at **1-866-841-7659**.