Provider Manual | July 2026

Primary Care | Specialist | Ancillary | Hospital

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Keystone First

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Introduction

About Keystone First – CHIP

The Children's Health Insurance Program (CHIP) is a Pennsylvania state-wide federally funded insurance program. Keystone First – CHIP, a managed care organization, provides health insurance to children and teens under the age of 19 in Bucks, Chester, Delaware, Montgomery and Philadelphia counties, who are not eligible for or enrolled in Medical Assistance or covered by private insurance, regardless of family income. We provide services that include inpatient care, emergency room visits, office visits, preventive care, behavioral health and substance use services, diagnostic services, therapies, home health visits, durable medical equipment, pharmacy, dental (including orthodontia, when medically necessary), and vision services.

Important Keystone First – CHIP Telephone Numbers

Department	Phone	Fax
Behavioral Health Services – PerformCare	1-877-244-7124	
Telephonic Psychiatric Consultation Team Services	1-267-426-1776	
Bright Futures	1-844-377-2447	
Bright Start Maternity (Prenatal) Program	1-800-521-6867	1-866-405-7946
Care Management Program	1-844-377-2447	1-215-937-8100
Change Healthcare Provider Support Line	1-877-363-3666	
ChildLine (DHS number to report suspected child abuse)	1-800-932-0313	
Contracting Department	1-866-546-7972	
Credentialing Department	1-833-806-2733	1-833-704-1182
Dental Benefits	1-855-343-7401	
EDI Technical Support Unit	1-877-234-4271	
Enrollee Services Department	1-844-472-2447	1-855-329-0067
Evolent (Outpatient Radiology Services)	1-800-424-1779	
Keystone First – CHIP Fraud & Abuse Hotline	1-866-833-9718	
MEDTOX	1-800-FOR LEAD	
NaviNet Customer Service	1-888-482-8057	
Nurseline Support	1-877-625-2447	
Pennsylvania Eligibility Verification System	1-800-766-5387	
Pennsylvania Tobacco Cessation Information	1-800-784-8669	
Peer-to-peer	1-833-762-4727	
Pharmacy Services/Prior Authorization Department	1-844-779-2447	1-833-873-2908
Prior Authorization	1-877-486-2447	1-844-586-3296
Provider Claim Services Unit	1-800-521-6007	1-215-863-5735
Provider Network Management	1-800-521-6007	1-215-937-5343
Provider Services Department	1-800-521-6007	1-855-329-0077
Quality Assessment and Performance Improvement	1-215-937-8612	1-215-937-8270

Department	Phone	Fax
Rapid Response Enhanced Member Supports Unit (EMSU)	1-844-377-2447	1-833-762-7708
TTY - Telecommunications for the Hearing Impaired	711	
Utilization Management	1-877-486-2447	1-844-586-3296
Vision Benefit Administrator (Davis Vision)	1-800-773-2847	1-800-933-9375

Important Definitions

Abuse	Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to Children's Health Insurance Program (CHIP), or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFA, Agreement, and the requirements of state law or federal regulations) for health care in a managed care setting. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider or entity has not knowingly or intentionally misrepresented facts to obtain payment. The Abuse can be committed by the Children's Health Insurance Program Managed Care Organization (CHIP-MCO), Subcontractor, Provider, State employee, or an Enrollee, among others. Abuse also includes Enrollee practices that result in unnecessary cost to CHIP, the CHIP-MCO, a Subcontractor, or Provider.
Adjudicated Claim	A Claim that has been processed to payment or denial.
Administrative denial	An adverse benefit determination of prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy. The term does not include an adverse benefit determination subject to the external review.
Alternate Payment Name	The person to whom benefits are issued on behalf of a Recipient.
Ambulatory Surgical Center	A facility licensed by the Department of Health which provides outpatient surgical treatment. The term does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.
Amended Claim	A Provider request to adjust the payment of a previously Adjudicated Claim. A Provider Appeal is not an Amended Claim.
Behavioral Health Primary Contractor	A county, Multi-County Entity or a Behavioral Health Managed Care Organization (BH-MCO) which has an Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

Behavioral Health Rehabilitation Services for Children and Adolescents (formerly Early and Periodic Screening, Diagnosis and Treatment [EPSDT] "Wraparound")	Individualized, therapeutic mental health, substance abuse or behavioral interventions/services developed and recommended by an interagency team and prescribed by a physician or licensed psychologist.
Behavioral Health Services	Mental health and substance abuse services provided as part of CHIP and outlined within the CHIP State Plan.
Behavioral Health Services Provider	A Provider, practitioner, or vendor/supplier which contracts to provide Behavioral Health Services or ordering or referring those services and is legally authorized to do so by the Department.
Business Day	A Business Day includes Monday through Friday except for those days recognized as federal holidays or Pennsylvania State holidays.
Caregiver	A person employed for compensation by a provider or Enrollee who provides personal assistance services or respite services for the purpose of providing a covered service by a healthcare worker on the staff/under contract.
Case Payment Name	The person in whose name benefits are issued.
Centers for Medicare & Medicaid Services	The federal agency within the Department of Health and Human Services responsible for oversight of Medical Assistance (MA) Programs.
Certified Nurse Midwife	An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. §§171-176.
Certified Registered Nurse Practitioner (CRNP)	A professional nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.
Claim	A bill from a Provider of a medical service or product that is assigned a unique identifier (i.e., Claim reference number). A

	Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.
Clean Claim	A Claim that can be processed without obtaining additional information from the Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the CHIP-MCO's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.
Complaint	1. A Complaint regarding an adverse benefit determination: A dispute or objection regarding: • a denial because the requested service or item is not a covered service; • the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department; • the failure of the CHIP-MCO to decide a Complaint or Grievance within the specified time frames; • a denial of payment by the CHIP-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in CHIP; • a denial of payment by the CHIP-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Enrollee; or • a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities. 2. A Complaint without an adverse benefit determination is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Complaint includes an enrollee's right to dispute an extension of time proposed by the CHIP-MCO to make an authorization decision. These types

	of complaints do not have a filing timeframe. This term does not include a Grievance.
Concurrent Review	A review conducted by the CHIP-MCO during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.
County Assistance Office	The county offices of the Department that administer all benefit programs, including CHIP, on the local level. Department staff in these offices perform necessary functions such as determining and maintaining Enrollee eligibility.
Cultural Competency	The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
Day	Indicates a calendar day unless specifically denoted otherwise. See Business Day.
Denial of Services	Any determination made by the CHIP-MCO in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s) but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the CHIP-MCO during the authorized period does not constitute a Denial of Service.
Denied Claim	An Adjudicated Claim that does not result in a payment obligation to a Provider.
Department	The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.
DHS Fair Hearing	A hearing conducted by the Department's Bureau of Hearings and Appeals for CHIP regarding an eligibility determination.
Disease Management	An integrated treatment approach that includes the collaboration and coordination of patient care delivery

	systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.
Disenrollment	The process by which an Enrollee's ability to receive services from a CHIP-MCO is terminated.
Drug Efficacy Study Implementation	Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA).
Durable Medical Equipment (DME)	Equipment furnished by a supplier or a home health agency that meets the following conditions: (a) can withstand repeated use (bis primarily and customarily used to serve a medical purpose (c) generally is not useful to an individual in the absence of a disability, illness or injury (d) can be reusable or removable and (e) is appropriate for use in any setting in which normal life activities take place.
Early Intervention Services	The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.
Eligibility Period	A period of time during which a consumer is eligible to receive CHIP benefits. An Eligibility Period is indicated by the eligibility start and end dates on Client Information System (CIS/eCIS).
Eligibility Verification System	An automated system available to CHIP Providers and other specified organizations for automated verification of CHIP Enrollee's current and past (up to three hundred sixty-five [365] days) MA and CHIP eligibility, CHIP-MCO Enrollment, Primary Care Practitioner (PCP) assignment, Third Party Resources (TPR) and scope of benefits.

Emergency Enrollee Issue	A problem of a CHIP-MCO Enrollee, including problems related to whether an individual is an Enrollee, the resolution of which should occur immediately or before the beginning of the next Business Day in order to prevent a denial or significant delay in care to the Enrollee that could precipitate an Emergency Medical Condition or need for urgent care.
Emergency Medical Condition	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: (a) 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, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.
Emergency Services	Covered inpatient and outpatient services that: (a) are furnished by a Provider that is qualified to furnish such service under 42 U.S.C 1397bb of the Social Security Act and (b) are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any covered health care service provided to an Enrollee, regardless of whether it has an associated Claim.
Encounter Data	A record of any Encounter, including Encounters reimbursed through Capitation, or other methods of compensation regardless of whether payment is due or made.
Enrollee	An individual who is enrolled with a CHIP-MCO under CHIP and for whom the CHIP-MCO has agreed to arrange the provision of CHIP Services under the provisions of CHIP.
Enrollment	The process by which an Enrollee's coverage by a CHIP-MCO is initiated.
Enrollment Month	One Enrollee covered by CHIP for one (1) calendar month.
Experimental Procedures	A course of treatment, procedure, device, or other medical intervention that is not yet recognized by the professional medical community as an effective, safe, and proven treatment for the condition for which it is being used.

Family Planning Services	Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies.
Federally Qualified Health Center (FQHC)	An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under the above-mentioned sections of the Act.
Formulary	A Department-approved list of outpatient drugs determined by the CHIP-MCO's Pharmacy & Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the CHIP-MCO Enrollees.
Fraud	Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the CHIP-MCO, a subcontractor, a Provider, or an Enrollee, among others.
Grievance	A request to have a CHIP-MCO or utilization review entity reconsider an adverse benefit determination concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a CHIP-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. 5) deny a request for a Benefit Limit Exception (BLE). This term does not include a Complaint.
Health Care-Associated Infection	A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: 1. occurs in a patient in a health care setting; 2. was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and

	3. if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.
Health Care Provider or Provider	A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, public health dental hygiene practitioner, pharmacist or an individual accredited or certified to provide behavioral health services.
Health Information Organization	An organization that serves as a Health Information Exchange that allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically.
Health Maintenance Organization (HMO)	A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Enrollees for a fixed, prepaid fee.
Health-related social needs (HRSN)	Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes, which can lead to inequities and risks.
Indian Health Care Provider	A health care program, including Contract Health Services (CHS), operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
Information Resource Management	A program planned, developed, implemented, and managed by DHS's Bureau of Information Systems, the purpose of which is to ensure the coordinated, effective, and efficient employment of information resources in support of DHS business goals and objectives.

Limited English Proficient (LEP)	Enrollees or Potential Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English, may be eligible to receive language assistance for a particular type of service, benefit or encounter.
Long-Term Services and Supports (LTSS)	Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
Managed Care Organization (MCO)	An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is: (1) Federally qualified HMO that meets the requirements of 42 CFR § 489 Subpart I or (2) Makes the services it provides its CHIP Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to tother CHIP beneficiaries within the area served by the entity; and (3) meets the solvency standards of 42 CFR § 438.116.
Managed Care Program	A managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.
Managed Care Program Zones (MCP Zone)	A multiple-county area in which CHIP has been implemented to provide mandatory managed care to CHIP Enrollees in Pennsylvania.
Medicaid Management Information System (MMIS) Provider ID	A 13-digit number consisting of a combination of the 9-digit base Master Provider Index (MPI) Provider Number and a 4-digit service location.
Medically Necessary	A service or benefit that is compensable under the CHIP Program and if it meets any one of the following standards: • The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability. • The service, item, procedure, or level of care will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability. • The service, item, procedure, or level of care will assist the Enrollee to achieve or maintain maximum

	functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for Enrollees of the same age.
Network	All contracted or employed Providers in the CHIP-MCO who are providing covered services to Enrollees.
Network Provider	Any provider, group of providers, or entity that has a network provider agreement with a CHIP-MCO or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with a CHIP-MCO. A network provider is not a Subcontractor by virtue of the network provider agreement.
Non-participating Provider	A Health Care Provider not enrolled in the Pennsylvania Medicaid or CHIP.
Nursing Facility	A general, county or hospital-based nursing facility, which is licensed by the DOH.
Ongoing Medication	A medication that has been previously dispensed to the Enrollee for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered necessary by the physician or prescriber, and that has been used by the Enrollee without a gap in treatment.
Other Resources	With regard to Third Party Liability (TPL), Other Resources include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.
Out-of-Area Covered Services	Medical services provided to Enrollee under one (1) or more of the following circumstances: • An Emergency Medical Condition that occurs while outside the Enrollee's • Managed Care Program Zone; • The health of the Enrollee would be endangered if the Enrollee returned to his or her Managed Care Program Zone for needed services; • The Provider is located outside the Enrollee's Managed Care Program Zone, but regularly provides medical services to Enrollees at the request of the CHIP-MCO; or

	• The needed medical services are not available in the Enrollee's Managed Care Program Zone.
Out-of-Network Provider	A Health Care Provider who has not been credentialed by and does not have a signed Provider Agreement with the CHIP-MCO.
Out-of-Plan Services	Services which are non-plan, non-capitated and are not the responsibility of the CHIP-MCO under the CHIP State Plan.
Outpatient Drug	A brand name drug, a generic drug, or an over the counter (OTC) drug which: 1. Is approved by the Federal Food and Drug Administration. 2. May be dispensed only upon prescription in CHIP. 3. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice. 4. Is dispensed or administered in an outpatient setting. The term includes biological products and insulin.
Patient Centered Medical Home	This model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.
Pennsylvania Children's Health Insurance State Plan	The Centers for Medicare and Medicaid approved template outlining services and administrative requirements for the Children's Health Insurance Program in Pennsylvania.
Physical Health Services	Those medical and other related services, provided to Enrollees, for which the CHIP-MCO has assumed coverage responsibility under this Agreement and as outlined in the CHIP State Plan.
Premium	An amount to be paid for an insurance policy.
Prepayment Review	Prepayment review is performed after the service or item is provided, but prior to payment being issued. Prepayment review may include the examination of an invoice and related documentation to determine eligibility, benefit packages, or medical necessity of a service or item before payment is made to the provider. Pre-payment review is not synonymous with prior authorization.

Prescription Drugs	Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: (1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.
Prevalent	A non-English language determined to be spoken by a significant number or percentage of Potential Enrollees that are limited English proficient. (42 CFR 457.1207 referencing CFR§ 438.10(a)).
Primary Care	All health care services, and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State CHIP, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.
Primary Care Practitioner (PCP)	A specific physician, physician group or a CRNP operating under the scope of his or her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of an Enrollee.
Prior Authorization	A determination made by the CHIP-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to an Enrollee prior to the Provider's initiation or continuation of the requested service.
Prior Authorized Services	State Plan Services, determined to be Medically Necessary, the utilization of which the CHIP-MCO manages in accordance with Department-approved Prior Authorization policies and procedures.
Provider	An individual or entity that is engaged in the delivery of medical or professional services, or ordering or referring for

	those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, and an individual accredited or certified to provide behavioral health services.
Provider Agreement	A Department-approved written agreement between the CHIP-MCO and a Provider to provide medical or professional services to Enrollees to fulfill the requirements of this Agreement.
Provider Appeal	A request from a Provider for reversal of a determination by the CHIP-MCO, with regard to: • Provider credentialing denial by the CHIP-MCO; • Claims denied by the CHIP-MCO for Providers participating in the CHIP-MCO's Network. This includes payment denied for services already rendered by the Provider to the Member; and • Provider Agreement termination by the CHIP-MCO.
Provider Dispute	A written communication to a CHIP-MCO, made by a Provider, expressing dissatisfaction with a CHIP-MCO decision that directly impacts the Provider. This does not include decisions concerning medical necessity.
Provider Reimbursement and Operations Management Information System electronic (PROMISe™)	The Department's current MMIS claims processing and management system that supports the CHIP, Fee-for-Service (FFS) and MA Managed Care delivery programs.
Quality Management	An ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care.
Rehabilitative Services	This includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for maximum reduction of physical or mental disability and

	restoration of a beneficiary to his best possible functional level.
Rejected Claim	A non-claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication.
Residential Treatment Facility	A facility licensed by the Department that provides twenty-four (24) hour out-of-home care, supervision, and Medically Necessary mental health services.
Retrospective Review	A review conducted by the CHIP-MCO, DHS, or DHS vendor or designee to determine whether services were delivered as prescribed and consistent with the CHIP-MCO's payment policies and procedures in accordance with this Agreement.
Routine Care	Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings, and physical exams.
Rural Health Clinics (RHCs)	A facility that is engaged primarily in providing services that are typically furnished in outpatient clinics in underserved rural areas.
School-Based Health Center	A health care site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care and which participates in CHIP and adheres to Bright Futures standards and periodicity schedule.
School-Based Health Services	An array of Medically Necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well childcare and screening examinations in a School-Based Health Center.
Short Procedure Unit	A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic, or medical services.
Start Date	The first date on which the CHIP-MCO is operationally responsible and financially liable for the provision of Medically Necessary services to Enrollees.

State Plan Services	Services which are required by the Pennsylvania Children's Health Insurance State Plan.
Step Therapy	A type of Prior Authorization requirement, sometimes referred to as a fail first requirement, intended as a cost savings that begins drug therapy with the most cost-effective drug therapy, and progresses to other more costly therapies determined to be Medically Necessary.
Stop-Loss Protection	Coverage designed to limit the amount of financial loss experienced by a Health Care Provider.
Third Party Liability (TPL)	An individual entity or program's (e.g., Medicare) other than the CHIP-MCO financial responsibility for all or part of an Enrollee's health care expenses.
Third Party Resource (TPR)	Any individual, entity or program that is liable to pay all or part of the medical cost of injury, disease, or disability of an Enrollee. Examples of TPR include government insurance programs such as Medicare or CHAMPUS; private health insurance companies, or carriers; liability or casualty insurance; and court-ordered medical support.
Urgent Care Services	Services furnished to an individual who requires services to be furnished within twenty-four (24) hours in order to avoid the likely onset of an emergency medical condition.
Urgent Medical Condition	An illness, injury, or severe condition which under reasonable standards of medical practice, should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.
Utilization Management	An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.
Utilization Review Criteria	Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

Waste	The overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather misuse of resources.

Section I
Covered Benefits and Services

Who is eligible for CHIP?

A child who is:

- a resident of Pennsylvania for at least thirty (30) days prior to the date of enrollment (except newborns);
- a U.S. citizen, permanent/resident alien, temporary alien (under specific circumstances), or refugee;
- not covered by any other health insurance plan, self-insured plan, or self-funded plan;
- not eligible for, or covered by, Medical Assistance (Medicaid) offered through the Pennsylvania Department of Human Services (DHS);
- within guidelines based on family size and income;
- under the age of 19; and
- For Full-Cost CHIP Enrollees ONLY: Must not have other affordable health insurance available, which means coverage is not more than 10% of the family's annual income OR the premium cost is not more than 150% of the CHIP premium.

Who is Covered?

The child enrolled in the program and named on the Keystone First – CHIP ID card. Only the child named on the card is eligible to receive benefits.

Covered Benefits and Services

Benefits and services include, but are not necessarily limited to, the following:

- PCP office visits and retail health clinic visits
- Specialist office visits (co-pays apply and vary dependent upon free, low-cost or full-cost CHIP)
- Preventive care
- Inpatient hospital services
- Outpatient surgery
- Urgent care center (co-pays apply and vary dependent upon free, low-cost or full-cost CHIP)
- Emergency care (co-pays apply and vary dependent upon free, low-cost or full-cost CHIP*) *Does not apply if child is admitted
- Emergency Ambulance
- Autism spectrum disorder treatment
- Dental care (refer to Dental section for detailed list)
- Diabetes education, equipment and supplies
- Diagnostic services (imaging, medical and laboratory)
- DME and prosthetics
- Family planning (for prescription contraceptives, devices and counseling)
- Occupational, physical, speech therapy (limits may apply)
- Hearing care (limits may apply)
- Home Health care

- Hospice care
- Hospital services
- Injectable medications – Standard injectable drugs and Biotech/specialty injectable
- Maternity and obstetrical care
- Medical foods
- Outpatient Medical therapy services

For Enrollees with a life-threatening, degenerative, or disabling disease or condition, or Enrollees with other Special Healthcare Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at **1-800-521-6007**.

Important Note:
Keystone First – CHIP is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) require that all Providers, including those who order, refer or prescribe items or services for Keystone First – CHIP Enrollees, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed on the Keystone First Provider website at **www.keystonefirstchip.com.**

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Services Not Covered

For a complete and detailed list of services not covered, please refer to the appendix of this manual.

When in doubt about whether Keystone First – CHIP will pay for health care services, please contact the Provider Services Department at **1-800-521-6007**.

Enrollee Co-Payment Schedule

To see the current Keystone First – CHIP Enrollee Co-payment schedule, visit **www.keystonefirstchip.com**

Section II
Referral & Utilization Management Authorization Requirements

Utilization Management

Keystone First - CHIP's Utilization Management (UM) program establishes processes for an effective, efficient utilization management system. Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage. Keystone First - CHIP will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition of the member.

Keystone First - CHIP does not reward healthcare professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Prior authorization is not a guarantee of payment for the service authorized. Keystone First - CHIP reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued, and the service was provided.

Per the provider agreement, providers are required to comply fully with Keystone First – CHIP's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service.
- Providing clinical information to support medical necessity when requested.
- Permitting access to the member's medical information.
- Involving the Plan's medical management nurse and/or licensed clinician in discharge planning discussions and meetings.
- Providing the Plan with copies of plan of treatment, progress notes, and other clinical documentation, as required.

Providers are encouraged to use the **Prior Authorization Lookup Tool** on the Keystone First - CHIP website for the most up-to-date list of services requiring prior authorization.

Referral Requirements

When a PCP determines the need for medical services or treatment, which will be provided outside the office, he/she must approve and/or arrange referrals to a participating Specialist, hospital, or other outpatient facility. Although specialty services will not require a referral form, Keystone First – CHIP expects that primary care and specialty care physicians will continue to

follow and engage in a coordination of care process, in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

Keystone First – CHIP is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) require that all Providers, including those who order, refer, or prescribe items or services for Keystone First – CHIP Enrollees, must be enrolled in the Pennsylvania Medical Assistance (MA) Program.

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Resources – DHS offers an Enrolled Provider Lookup Function

The DHS lookup function allows enrolled Providers to verify that their colleagues who are ordering, prescribing, or referring services are enrolled in the Pennsylvania MA program. Access the lookup function at the following link: **https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18**

Services Requiring a Referral:

- Initial visits to a Specialist*/hospital or other outpatient facility
- Doula services require the completion of the Doula Services Recommendation form completed and signed by a physician or any licensed provider. Providers can support members requesting doula services by completing the Doula Services Recommendation form upon request. The Doula Services Recommendation Form is available on the website.

Services Not Requiring a Referral (Enrollee Self-Referral):

- Prenatal OB visits
- Routine OB/GYN visits
- Routine Family Planning Services. Enrollees may go to any doctor or clinic of their choice to obtain Family Planning Services.
- Routine Eye Exams **
- Prescription eyeglasses
- Routine Dental Services ***
- Emergency Services including emergency transportation
- Outpatient Behavioral Health, Drug and Alcohol treatment (Refer to the Behavioral Health Section.)
- Initial Chiropractic Visit/Evaluation (by an in-network provider)
- The following Diagnostic Tests performed on an outpatient basis with a prescription: Routine Mammograms, Chest X-rays, Ultrasounds, Non-Stress Tests, Pulmonary Function Tests

(Please refer to the Prior Authorization list in this section of the Manual for a list of radiological procedures that require Prior Authorization)
- Pre-Admission Testing and Stat Lab Services
- Diagnostic Tests and Procedures performed in a Short Procedure Unit, Ambulatory Surgery Center or Operating Room****
- Routine lab work with a prescription
- DME Purchases less than $750 if on MA Fee Schedule and with a prescription

* For Enrollees with a life-threatening, degenerative, or disabling disease or condition, or Enrollees with other Special Healthcare Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at **1-800-521-6007**.

** Some Specialty Eye Care Services may require a referral. See "**Ophthalmology Services**" in this Section in the Manual.

*** Some Dental Services may require Prior Authorization. See "**Dental Services**" in this section of the Manual.

Referral Process

The PCP should follow the steps outlined below prior to advising the Enrollee to access services outside of the office.

The PCP's office should:
- Verify Enrollee eligibility
- Determine if the needed service requires a referral or Prior Authorization from Keystone First – CHIP (See "Services Requiring Referrals and Prior Authorization" in this section of the Manual) or by using the Prior Authorization Look Up Tool on the plan website.
- Select a participating specialty provider/ hospital or other outpatient facility appropriate for the Enrollee's medical needs from the specialty provider Directory, as appropriate. There is also an online Network Provider Directory with search capability at **www.keystonefirstchip.com.** (If an appropriate Network Provider is not listed in the Network Provider Directory, please call Provider Services **1-800-521-6007** for assistance. See "**Out-of-Plan Referrals**" in this Section for additional information).

How to refer an Enrollee to a participating Keystone First – CHIP specialty provider:

The primary care physician may write a prescription, call, send a letter or fax a request to the specialty provider. The referral to the specialty provider must be documented in the Enrollee's medical record. The referring practitioner should communicate all appropriate clinical information directly to the specialty provider without involving the Enrollee. Provide the following information:

- Enrollee name and ID number.
- Reason for referral.
- Duration of care to be provided.
- All relevant medical information.

- Referring practitioner's name and Keystone First – CHIP ID number.

The Specialty provider office should:

- Contact the PCP if the Enrollee presents at the office and there has been no communication or indication of the reason for the visit from the PCP.
- Provide the services indicated by the PCP.
- Communicate, in accordance with applicable laws, findings, test results and treatment plan to the Enrollee's PCP. The PCP and specialty provider should jointly determine how care should proceed, including when the Enrollee should return to the PCP's care.
- Contact the PCP if the Enrollee needs to be referred to another specialty provider for consultation, treatment, etc.
- Claim payment is no longer tied to the presence of a referral; however, when submitting a claim for payment, the referring practitioner's information must be included in the appropriate boxes of the CMS-1500 form as required by CMS.

Follow-Up Specialty Office Visits

Although specialty services will not require a referral form, Keystone First – CHIP expects that primary care and specialty care physicians will continue to follow and engage in a coordination of care process, in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

The Specialty provider office should:

- Contact the PCP if the Enrollee presents at the office and there has been no communication or indication of the reason for the visit from the PCP.
- Provide the services indicated by the PCP.
- Communicate, in accordance with applicable laws, findings, test results and treatment plan to the Enrollee's PCP. The PCP and specialty provider should jointly determine how care should proceed, including when the Enrollee should return to the PCP's care.
- Contact the PCP if the Enrollee needs to be referred to another specialty provider for consultation, treatment, etc.
- Claim payment is no longer tied to the presence of a referral; however, when submitting a claim for payment, the referring practitioner's information must be included in the appropriate boxes of the CMS-1500 form as required by CMS.

When the Specialist requires that the Enrollee be referred to another Specialist, either for evaluation and management or a diagnostic or treatment procedure, this visit must be approved by the Enrollee's PCP. Either the Specialist's office or the Enrollee should advise the PCP office of the need for the follow up services. The PCP office should then follow the referral process. See "**Referral Process**" in this section of the Manual.

Out-of-Network Referrals

Occasionally, an Enrollee's needs cannot be provided through the Keystone First – CHIP Network. When the need for out-of-network services arises, the Network Provider should contact the Utilization Management Department for prior authorization. The Utilization

Management Department will review the request for out-of-network services for the Enrollee to receive the medically necessary services. Every effort will be made to locate a Specialty provider within easy access to the Enrollee.

If a Non-Participating Provider is approved, that Provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **1-800-521-6007**.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State Medicaid program before payment of a CHIP claim can be made. This applies to non-participating out-of-state Providers as well.

Enroll by visiting: **https://www.pa.gov/agencies/dhs/resources/for-providers/promise/promise-provider-enrollment.html**

Standing Referrals

For Enrollees with a life-threatening, degenerative or disabling disease or condition, or Enrollees with other Special Healthcare Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at **1-800-521-6007**.

Referrals/Second Opinions

No referral is required for second opinions, or consultations. Some services may require prior authorization.

Prior Authorization Requirements

The preferred prior authorization requests process is through NaviNet. A complete user guide can be found on our website.

Prior authorizations with Keystone First – CHIP are required for certain services for participating Providers. Please refer to our website for services requiring prior authorization.

For out of network Providers, prior authorization is required for all services except emergency services.

Reimbursement for all rendering Providers for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medicaid Provider ID. Claims submitted by rendering Providers will be denied if the ordering, referring, or prescribing Provider is not enrolled in the Pennsylvania Medical Assistance program.

To check enrollment status of the practitioner ordering, referring, or prescribing the service you are providing is enrolled in Medical Assistance visit the DHS Provider look-up portal at:

https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

Services Requiring Prior Authorization:

Physical Health Services Requiring Prior Authorization

The following is a list of services requiring prior authorization review for medical necessity and place of service.

- All elective (scheduled) inpatient hospital admissions, medical and surgical including rehabilitation.
- All elective transfers for inpatient and/or outpatient services between acute care facilities.
- All elective transplant evaluations and procedures.
- All miscellaneous/unlisted or not otherwise specified codes.
- All services that may be considered experimental and/or investigational.
- Any service(s) performed by non-participating or non-contracted practitioners or providers, unless the service is an emergency service.
- Cosmetic procedures regardless of treatment setting to include, but not limited to, the following:
    - Reduction mammoplasty
    - Gastroplasty
    - Ligation and stripping of veins
    - Rhinoplasty
- Durable Medical Equipment (DME)
    - DME monthly rental items regardless of the per month cost/charge.
    - Home Accessibility DME Equipment (refer to the DME section of the manual for complete details).
    - Purchase of all items greater than $750
    - Select wheelchair components
    - The purchase of all wheelchairs (motorized and manual) regardless of cost per item
- Elective/non-emergent Air Ambulance Transportation.
- Elective termination of pregnancy – Refer to the Termination of Pregnancy section of the Provider Manual for complete details.
- Enterals
    - Required when greater than $350 per month
- Genetic Testing.
- Home Health Services

  - Prior authorization is not required for up to 18 home visits per benefit period including:
    - Skilled nursing visits by an RN or LPN
    - Home Health Aide visits
    - Home Respiratory Therapy; Mechanical Ventilation Care; Stoma Care and Maintenance
    - Colostomy and Cystectomy
  - The duration of services may not exceed a 60-day period.
  - The enrollee must be re-evaluated every 60 days.
- Home Oxygen Therapy
  - All requests for oxygen and oxygen equipment require authorization.
  - Initial authorization is for 6 months and reauthorizations require an updated prescription with current oxygen saturation level (refer to the Durable Medical Equipment section for complete requirements and details).
- Incontinence Supplies
  - Age 3 and older.
  - Greater than $750.
- Injectables.
- Neurological Psychological Testing.
- Pain management services performed in a Short Procedure Unit (SPU) or Ambulatory Surgery Unit (either hospital-based or freestanding)
  - Pain management services not on the Medical Assistance fee schedule performed in a physician's office.
- Private Duty Nursing
- Radiology - The following outpatient services require prior authorization by Keystone First - CHIP's radiology benefits vendor, Evolent.
  - Positron Emission Tomography (PET)
  - Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
  - Nuclear Cardiology /MPI
  - Computed Axial Tomography (CT/CTA/CCTA)
  - Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.
  - Refer to the Radiology Services section for prior authorization details.
- Select gastroenterology services.
- Skilled Nursing Facility admission for alternate levels of care in:
  - A facility, either free-standing or part of a hospital that is of lesser intensity than that received in a hospital.
- Therapies – Physical Therapy, Occupational Therapy, Speech Therapy
  - Outpatient Habilitative – prior authorization is not required up to 60 visits per modality.
  - Outpatient Rehabilitative – prior authorization is not required up to 60 visits per modality.

Behavioral Health Services Requiring Prior Authorization

- The following services require prior authorization:
  - Autism Services / ABA
  - Mental Health Inpatient services
  - Mental Health Partial Hospitalization Services
  - Mental Health Intensive Outpatient Treatment
  - Outpatient Services: Electroconvulsive therapy
  - Psychological/Neuropsychological Testing
  - Substance Use Intensive Outpatient Services
  - Substance Use Inpatient Services
  - Substance Use Partial Hospitalization Services
- Providers must call Keystone First – CHIP at 1-877-244-7124 to request telephonic prior authorization for Mental Health Inpatient, Mental Health Partial Hospitalization, and Mental Health Intensive Outpatient Programs (IOP), Substance Use Inpatient, and Substance Use Partial Hospitalization, and Substance Use Intensive Outpatient Programs (IOP).
- Providers can request prior authorization for all other covered services requiring prior authorization via the Keystone First – CHIP NaviNet Provider Portal.
- Services Not Requiring a Referral (Enrollee Self-Referral)
  - Mental Health Outpatient Services
  - Substance Use Outpatient Services
  - Mental Health Intensive Outpatient Treatment
  - Substance Use Intensive Outpatient Services
  - Emergency Services

Select Prescription Medications. For information on which prescription drugs that require authorization, the Keystone First - CHIP Formulary can be found in the Provider Center at **www.keystonefirstchip.com**.

Select Dental services. For information on which dental services require authorization, please refer to the Dental Services Section of the Provider Manual.

Prior Authorization Lookup Tool

This user-friendly resource on our Plan website allows users to enter a Current Procedural Terminology (CPT) or a Healthcare Common Procedure Coding System (HCPCS) code to verify authorization requirements in real time before delivery of service.

To access the Prior Authorization Lookup tool, visit: **www.keystonefirstchip.com**

Confirming authorization requirements is as simple as entering a CPT code or a HCPCS code and clicking “submit”. The results of this tool are not a guarantee of coverage or authorization. All results are subject to change in accordance with plan policies and procedures.

The following information is required in order to properly assess a Provider's request for prior authorization: Enrollee's plan ID number, Enrollee's name, Enrollee's date of birth, diagnosis/ses (ICD-10), requested CPT codes, date of service, ordering/referring doctor's NPI, facility/treating providers NPI, applicable clinical information.

Prior authorization is not a guarantee of payment for the service(s) authorized. Keystone First – CHIP reserves the right to adjust any payment made following a review of the medical record and/or determination of medical necessity of the services provided. Additionally, payment may also be adjusted if the Enrollee's eligibility changes between when the authorization was issued and the service was provided.

Reimbursement for all rendering Providers for an approved authorization is determined by satisfying the mandatory requirement to have a valid Pennsylvania Medicaid Provider ID. Claims submitted by rendering Providers will be denied if the ordering, referring, or prescribing Provider is not enrolled in the Pennsylvania Medical Assistance program.

To check enrollment status of the practitioner ordering, referring, or prescribing the service you are providing is enrolled in Medical Assistance visit the DHS Provider look-up portal at:

https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx?mc_cid=b5b718e470&mc_eid=3de0fb2a18

Any additional questions regarding prior authorization requests may be addressed by calling Keystone First – CHIP Provider Services Department at **1-800-521-6007**.

Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.

Policies and Procedures

Medically Necessary

A service, item, procedure, or level of care compensable under the Keystone First – CHIP program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for Enrollees of the same age.

The determination is based on clinical information provided by the Enrollee, the Enrollee's family/caretaker, and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Enrollee. All such determinations must be made by qualified and trained practitioners.

Benefit Limits and Co-Payments

There may be benefit limits or co-payments* associated with the services mentioned in this section.

Please refer to the Benefits at a Glance on the Provider Center at **www.keystonefirstchip.com**.

* Network Providers and other Providers may not deny a covered service because an Enrollee is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

Authorization and Eligibility

Due to possible interruptions of an Enrollee's CHIP coverage, it is strongly recommended that Providers call for verification of an Enrollee's continued eligibility on the first 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 contact Keystone First – CHIP's Utilization Management Department to obtain Prior Authorization for continuation of service.

Ambulance

Keystone First – CHIP is responsible to coordinate and reimburse for **Medically Necessary** transportation by ambulance for physical, psychiatric, or behavioral health services.

Enrollees experiencing a medical emergency are instructed to immediately contact their local emergency rescue service - 911

Keystone First – CHIP has contracted with specific Ambulance Providers throughout the service area and will reimburse for Medically Necessary ambulance transportation services. For ambulance transportation to be considered Medically Necessary, one or more of the following conditions must exist:

- The Enrollee is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the Enrollee
- There is reason to suspect serious internal or head injury
- The Enrollee requires physical restraints
- The Enrollee requires life support treatment en route

- Because of the medical history of the Enrollee and present condition, there is reason to believe that life support treatment is required en route
- The Enrollee is being transported to the nearest appropriate medical facility
- The Enrollee is being transported to or from an appropriate medical facility in connection with services that are covered under the CHIP Program
- The Enrollee requires transportation from a hospital to a non-hospital drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not Medically Necessary in an inpatient facility

Behavioral Health Services

Enrollees may self-refer for outpatient behavioral health services. However, PCPs and other physical healthcare Providers often need to recommend that an Enrollee access behavioral health services. The Health Care Provider or his/her staff can obtain assistance for Enrollees needing behavioral health services by calling PerformCare at **1-877-244-7124.**

Cooperation between Network Providers and PerformCare is essential to assure Enrollees receive appropriate and effective care. Network Providers are required to:

- Adhere to state and Federal confidentiality guidelines for Enrollee medical records, including obtaining any required written Enrollee consents to disclose confidential mental health and drug and alcohol records.
- Refer Enrollees to PerformCare, 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 Enrollee is taking.
- Be available to the Behavioral Health Provider on a timely basis 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 Enrollee may receive appropriate support and services necessary to effectively treat the problem

PerformCare provides access to diagnostic, assessment, referral and treatment services including but not limited to:

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

Health Care Providers may call PerformCare's Enrollee Services Department at **1-884-524-2447** whenever they need help referring an Enrollee for behavioral health services.

Telephonic Psychiatric Consultation Team Services

In order to improve the quality of care for children and adolescents with behavioral health concerns that may require psychotropic medication, or assistance with accessing behavioral health services, Keystone First – CHIP will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children. The PCT for Keystone First – CHIP is Children's Hospital of Philadelphia (CHOP) at **1-267-426-1776**.

The PCT will be available between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the Keystone First – CHIP Program Zone to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family:

1. Resolution of the PCP's inquiry to the satisfaction of the PCP;
2. Referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits;
3. Referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the Enrollee's family; or
4. Referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the Keystone First – CHIP Program Zone to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the Geographic Service Area with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

Providers seeking a telephonic psychiatric consultation should call Children's Hospital of Philadelphia (CHOP) at **1-267-426-1776**.

For more information and program details, please visit **https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/tips.html#:~:text=TiPS%20is%20a%20HealthChoices%20program,of%20psychotropic%20medications%20for%20children**

Dental Services

Enrollees do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network. Enrollee inquiries regarding covered dental services should be directed to Keystone First – CHIP's Enrollee Services Department at **1-844-472-2447**.

Providers with inquiries regarding covered dental services should call Keystone First – CHIP Dental Provider Services at **1-855-343-7401**. Provider Services staff are available **Monday-Friday 8:00A.M. – 5:00 P.M. EST.**

Please refer to the Dental Provider Supplement of this manual for complete and detailed Dental procedures and policies.

Dental Benefits

Enrollees are eligible to receive all covered dental services which are Medically Necessary. Children may go to any dentist that is part of Keystone First – CHIP's network.

Participating dentists can be found in our online Provider directory at **www.keystonefirstchip.com** or by calling Enrollee Services at **1-844-472-2447**.

Dental services that are covered include the following, when medically necessary:
(certain exceptions may apply, see Keystone First – CHIP Dental Provider Supplement for specifics)

- Oral Evaluations
- Radiographs
- Prophylaxis
- Fluoride Treatments**
- Sealants
- Silver Diamine Fluoride
- Restorative services
- Crowns*
- Endodontic services*
- Periodontal services*
- Extractions
- Dental surgical services*
- Anesthesia*
- Prosthodontic services*
- Orthodontic services*

* Prior Authorization is required and medical necessity must be demonstrated.

**Participating PCPs and CRNPs with appropriate training may administer and bill for topical application of fluoride varnish for children less than five (5) years old two times per year.

Topical application of fluoride varnish is defined as a service provided by a participating PCP or CRNP during which each tooth of a child (less than 5 years old) is painted with a fluoride solution under a specific application protocol.

Providers are encouraged to take the on-line "*Caries Risk Assessment, Fluoride Varnish & Counseling"* educational course before administering fluoride varnish to assigned Enrollees less than five (5) years old. The link to the training module is available in the Provider Center at **www.keystonefirstchip.com**.

PCPs are expected to refer each child receiving a fluoride varnish treatment to a pediatric dentist or general dentist for follow-up dental care. Provision of this dental-related preventive service by the PCP to young children is designed as a gateway to regular dental care and is not conceived or intended to be provided regularly, year-after-year, for the same child, in the absence of a dental home.

Durable Medical Equipment

Covered Services

Keystone First – CHIP Enrollees are eligible to receive Medically Necessary durable medical equipment (DME) needed for home use.

All DME purchases that cost more than $750, DME monthly rental items regardless of the per month cost/charge.

All wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or Enrollee age must be Prior Authorized.

Home Oxygen Therapy

Initial authorizations are for 3 months. Reauthorizations will require a re-evaluation and updated clinical including oxygen saturation levels. Requests for home oxygen therapy should be accompanied by a current signed prescription and a letter of medical necessity from the treating Provider that includes:

- Diagnosis
- Documented oxygen saturation levels within the past twelve months
- How many liters per minute the Enrollee is to be using
- Will the use be continuous, nocturnally or as needed.

PCPs, Specialty providers and Hospital Discharge Planners are directed to contact Keystone First – CHIP's Utilization Management Department via phone, fax, or provider portal. Because Enrollees may lose eligibility or switch plans, DME Providers are directed to contact Enrollee Services for verification of the Enrollee's continued CHIP eligibility and continued enrollment with Keystone First – CHIP when equipment is authorized for more than a one-month period of time. Failure to do so could result in Claim denials.

Occasionally, Enrollees require equipment or supplies that are not traditionally included in the CHIP Program. Keystone First – CHIP 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 CHIP 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 Keystone First – CHIP. Please contact our Utilization Management Department electronically through NaviNet Provider Portal or via phone at **1-877-486-2447** or fax **1-844-586-3296**.

The letter of medical necessity must contain the following information:

- Enrollee's name
- Enrollee's ID number
- The item being requested
- Expected duration of use
- A specific diagnosis and medical reason that necessitates use of the requested item.

Each request is reviewed by a Keystone First – CHIP Physician Advisor. Occasionally, additional information is required, and the Provider will be notified by Keystone First – CHIP of the need for such information. If you have questions regarding any item or supply, please contact the Provider Services Department at **1-800-521-6007**.

Elective Admissions and Elective Outpatient Setting Procedures

In order for Keystone First – CHIP to monitor quality of care and utilization of services, all Providers are required to obtain Prior Authorization from the Utilization Management Department for all non-emergency elective medical/surgical inpatient hospital admissions, as well as certain specific procedures performed in an outpatient setting. See "Prior Authorization Requirements" earlier in this Section.

- In order to qualify for payment, Prior Authorization is mandatory for designated procedures done in an outpatient setting and elective admissions.
- Keystone First – CHIP will accept the hospital or the attending Network Provider's request for Prior Authorization of elective inpatient hospital and/or outpatient admissions, however, neither party should assume the other has obtained Prior Authorization
- To prior authorize an elective inpatient or outpatient procedure, practitioners are requested to contact the Utilization Management Department **via phone, fax, or NaviNet Portal.**
- The Prior Authorization request will be reviewed for medical necessity
- Procedures scheduled for the following calendar month can be reviewed for medical necessity; however, Keystone First – CHIP cannot verify the Enrollee's eligibility for the date of service. The Network Provider is required to verify eligibility prior to delivering care. Contact the Provider Services Department at **1-800-521-6007** or check eligibility online at **www.navinet.net**.
- Outpatient procedures, which have been prior authorized for a particular date, may require rescheduling. If the procedure has been approved and the dates of service need to be updated/changed, Please contact the Keystone First - CHIP Utilization Management

Department. Should the rescheduled date cross a calendar month, the Network Provider is responsible for verifying that the Enrollee is still eligible with Keystone First – CHIP before providing the service.

Peer-to-Peer Review

Keystone First - CHIP provides the opportunity for Network and Non-Participating Providers to discuss the Utilization Management (UM) Medical Necessity determination of a denial or decrease in level of care with Medical Director. The UM team that conducts peer-to-peer consultations are health care professionals that have clinical expertise in treating the Enrollee's condition, with the equivalent or higher credentials than that of the requesting or ordering provider.

The Medical Director will use accepted clinical guidelines when conducting peer-to-peer consultations. The Medical Director will clearly identify what documentation the provider must furnish to obtain approval of the specific item, procedure, or service. The Medical Director may recommend a more appropriate course of action based upon accepted clinical guidelines as a result of the peer-to-peer discussion.

The timeframes for a Peer-to-Peer request are:

- At any time while the Enrollee is still inpatient
- Up to 5 business days after the Enrollee's discharge date.
- Up to 5 business days after a determination for a prior authorization (Pre-Service) request has been rendered.

If you would like to request a Peer-to-Peer, please call the UM department at **1-877-486-2477**.

See "Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances" in Section VII of this Manual for information on how to file an appeal.

Emergency Admissions, Surgical Procedures and Observation Stays

Enrollees often present to the ER with medical conditions of such severity, that further or continued treatment, services, and medical management is necessary. In such cases, the ER staff should provide stabilization and/or treatment services, assess the Enrollee's response to treatment and determine the need for continued care. To obtain payment for services delivered to Enrollees requiring admission to the inpatient setting, the hospital is required to notify Keystone First – CHIP of the admission within 24 hours and provide clinical information to establish medical necessity within 48 hours. Keystone First – CHIP performs Concurrent Review of inpatient hospitalizations to assess the Medical Necessity of an inpatient stay based on the Enrollee's clinical information, to evaluate appropriate utilization of inpatient services, and promote delivery of quality care on a timely basis.

An appropriate level of care, for an admission from the ER, may be any one of the following:

- ER Medical Care

- Emergency outpatient Service
- Emergent Observations Stay Services - Maternity & Other Medical/Surgical Conditions
- Emergency Inpatient Admission
- Emergency Medical Services

Emergency Medical Services

ER Medical Care

ER Medical Care is defined as an admission to the Emergency Department for an Emergency Medical Condition where short-term medical care and monitoring are necessary.

Important Note: Keystone First – CHIP is prohibited from making payment for items or services to any financial institution or entity located outside of the United States and its territories.

All Providers, particularly emergency, critical care and urgent care Providers must be alert for the signs of suspected child abuse, and as mandatory reporters under the Child Protective Services law, know their legal responsibility to report such suspicions.

To make a report call:

- Childline – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

A mandated reporter making an oral report of suspected child abuse to the department via the Statewide toll-free telephone number (800-932-0313) must also make a written report, which may be submitted electronically within 48 hours to the department or county agency assigned to the case by using the CY-47 Report of Suspected Child Abuse form, found here: **http://www.keepkidssafe.pa.gov/resources/forms/**

Additional resources addressing mandatory reporter requirements:

- The Juvenile Law Center of Philadelphia, Child Abuse and the Law: (**http://www.jlc.org/resources/publications/child-abuse-and-law**)
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**
- Keystone First – CHIP's dedicated web page to child abuse prevention on the Provider center at **www.keystonefirstchip.com**

In 2010, the Adult Protective Services (APS) Law, **Act 70 of 2010**, was enacted to provide protective services to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities. The APS Law establishes a program of protective services to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need.

A report can be made on behalf of the adult whether they live in their home or in a care facility such as a nursing facility, group home, hospital, etc. Reporters may remain anonymous and have

legal protection from retaliation, discrimination, and civil and criminal prosecution. The statewide Protective Services hotline is available 24 hours a day.

Abuse or neglect of Plan Enrollees age of 18-59 may be reported to Adult Protective Services by calling **1-800-490-8505.**

Additional resources are located at **https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Adult-Protective-Services.aspx**

Emergency Room Policy

"An Emergency Medical Condition" is 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

Prior Authorization/Notification for ER Services/Payment:

Keystone First – CHIP does not require Prior Authorization or prior notification of services rendered in the ER. ER staff should immediately screen all Enrollees presenting to the ER and provide appropriate stabilization and/or treatment services. Reimbursement for Emergency Services will be made at the contracted rate. Keystone First – CHIP reserves the right to request the emergency room medical record to verify the Emergency Services provided.

PCP Contact Prior to ER Visit

It is recommended that an Enrollee should present to the ER after contacting his/her PCP. Enrollees are encouraged to contact their PCP to obtain medical advice or treatment options about conditions that may/may not require ER treatment. Prior Authorization or prior notification of services rendered in the ER is not required.

Authorization of Inpatient Admission Following ER Medical Care

If an Enrollee is admitted as an inpatient following ER Medical Care, authorization is required. Contact the Utilization Management Department electronically through NaviNet Provider Portal or via phone at **1-877-486-2447** or fax **1-844-586-3296** within 24 hours of admission. See the Provider Services section of the manual for details on how to access Medical Authorizations through Navi Net Provider Portal. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period within 48 hours of admission. The information should include treatment received in the ER; the response to treatment; result of post-treatment diagnostic tests; and the treatment plan. All ER charges are to be included on the inpatient billing form. Reimbursement for authorized

admissions will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER Services. The inpatient case reference number should be noted on the bill.

Emergent Observation Stay Services

Keystone First – CHIP considers Observation Care to be an outpatient service. Observation Care is often initiated as the result of a visit to an ER when continued monitoring or treatment is required.

Observation Care can be broken down into two categories:

- Maternity Observation, and
- Medical Observation (usually managed in the outpatient treatment setting)

Maternity/Obstetrical Observation Stay

A Maternity Observation Stay is defined as a stay for the monitoring and treatment of patients with medical conditions related to pregnancy not requiring inpatient admission including but not limited to:

- Symptoms of premature labor
- Abdominal pain
- Abdominal trauma
- Vaginal bleeding
- Diminished or absent fetal movement
- Premature rupture of membranes (PROM)
- Pregnancy induced hypertension/Preeclampsia
- Hyperemesis
- Gestational Diabetes

Enrollees presenting to the ER with medical conditions related to pregnancy should be referred, whether the medical condition related to the pregnancy is an emergency or non-emergency, to the Labor and Delivery Unit (L & D Unit) for evaluation and observation. **Authorization is not required for Maternity/Obstetrical Observation at participating facilities. These services should be billed with Revenue Codes 720 – 729.**

ER Medical Care rendered to a pregnant Enrollee that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation.

Authorization of Inpatient Admission Following OB Observation

If an Enrollee is admitted after being observed, notification is required within 24 hours to the Utilization Management Department via phone, fax, or provider portal for authorization, or electronically through Medical Authorizations NaviNet Patient Portal. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet. If the hospital does not have an L&D Unit, the hospital ER staff will include in their medical screening a determination of the appropriateness of treating the Enrollee at the hospital versus

the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For Enrollees who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest Keystone First – CHIP participating hospital. Hospitals where Enrollees are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a weekend, the hospital staff should facilitate the transfer and notify Keystone First – CHIP's Patient Utilization Management Department via a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and Enrollee eligibility. All ER and Observation Care charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient case reference number should be noted on all Claims related to the inpatient stay.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances" in Section VII of the Manual.

Medical Observation Stay

A Medical Observation Stay is defined by clinical status of the patient not the length of hospital time that determines observation stay. Observation level of care may be considered for patients with medical conditions including but not limited to:

- Head Trauma
- Chest Pain
- Post trauma/accidents
- Sickle Cell disease
- Asthma
- Abdominal Pain
- Seizure
- Anemia
- Syncope
- Pneumonia

Enrollees presenting to the ER with Emergency Medical Conditions should receive a medical screening examination to determine the extent of treatment required to stabilize the condition. The ER staff must determine if the Enrollee's condition has stabilized enough to warrant a discharge or whether it is medically appropriate to transfer to an "observation" or other "holding" area of the hospital, as opposed to remaining in the ER setting. **Authorization is not required for a Medical Observation Stay.**

Authorization of Inpatient Admission Following Medical Observation

If an Enrollee is admitted as an inpatient following a Medical Observation Stay, notification is required within 24 hours to the Utilization Management Department at **1-877-486-2447 or by fax at 844-586-3296** for authorization or electronically through Medical Authorizations on the Provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access Medical Authorizations through NaviNet. The Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the Enrollee as an inpatient versus retention in the Observation Care setting of the facility. If the Enrollee is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all Claims related to the inpatient stay.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances" in Section VII of the Manual.

Utilization Management Inpatient Stay Continued Stay Review

The Utilization Management (UM) Department is mandated by the Department of Human Services to monitor the progress of an Enrollee's inpatient hospital stay. This is accomplished by the UM Department through the review of appropriate Enrollee clinical information from the Hospital. Hospitals are required to provide Keystone First – CHIP, within two (2) business days from the date of an Enrollee's admission (unless a shorter timeframe is specifically stated elsewhere in this Provider Manual), all appropriate clinical information that details the Enrollee's admission information, progress to date, and any pertinent data.

As a condition of participation in the Keystone First – CHIP Network, Providers must agree to the UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days, according to established criteria, under the direction of the Keystone First – CHIP Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, Keystone First – CHIP must receive all clinical information on the continued inpatient stay no later than the last covered day.

Emergency Services Provided by Non-Participating Providers

Keystone First – CHIP will reimburse Health Care Providers who are not enrolled with Keystone First – CHIP when they provide Emergency Services for a Keystone First – CHIP Enrollee.

However, to comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State CHIP program before a payment of a CHIP claim can be made.

Important note: This does not apply to non-participating out-of-state Providers under single case agreements.

DHS may make a determination that adopts encounter limits or thresholds that would require the non-participating out-of-state Providers to convert to in-network status, which would require enrollment in the Pennsylvania CHIP Program.

Enroll by visiting: **https://www.pa.gov/agencies/dhs/resources/for-providers/promise/promise-provider-enrollment.html**

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania CHIP program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania CHIP enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled CHIP Provider.

The Health Care Provider must obtain a Non-Participating Keystone First – CHIP Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **1-800-521-6007**.

Please note that applying for and receiving a Non-Participating Provider number after the provision of Emergency Services is for reimbursement purposes only. It does not create a participating Provider relationship with Keystone First – CHIP and does not replace Provider enrollment and credentialing activities with Keystone First – CHIP (or any other health care plan) for new and existing Network Providers.

Important Note: Keystone First – CHIP is prohibited from making payment for items or services to any financial institution or entity located outside of the United States and its territories.

Family Planning

Enrollees are covered for Family Planning Services without a referral or Prior Authorization from Keystone First – CHIP. Enrollees may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Keystone First – CHIP Network. Enrollees that have questions or need help locating a Family Planning Services Provider can be referred to Enrollee Services at **1-844-472-2447**.

Keystone First – CHIP Enrollees are entitled to receive family planning services without a referral or co-pay, including:

- Medical history and physical examination (including pelvic and breast)
- Diagnostic and laboratory tests
- Drugs and biologicals
- Medical supplies and devices
- Counseling
- Continuing medical supervision

- Continuing care and genetic counseling

Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinical) drugs, laboratory, radiological and diagnostic and surgical procedures are not covered.

Home Health Care

Keystone First – CHIP 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 Enrollees who could effectively be treated at home
- To allow Enrollees to receive care when they are homebound, meaning their condition or illness restricts their ability to leave their residence without assistance or makes leaving their residence medically contraindicated.

Home Health Care should be utilized for the following types of services:

- Skilled Nursing
- Infusion Services
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Medical Social Worker
- Home Dietician Therapy

Keystone First – CHIP's **Special Healthcare Needs/Care Management Department** will coordinate Medically Necessary home care needs with the PCP, attending specialist, hospital home care departments and other Providers of home care services. Contact Keystone First – CHIP's **Special Care/Care Management Department** at **1-844-377-2447.**

Due to possible interruptions of the Enrollee's CHIP coverage, it is strongly recommended that Providers call for verification of the Enrollee's continued eligibility on the 1st of each month. If the need for service extends beyond the initial authorized period, the Provider must call Keystone First – CHIP's Utilization Management Department to obtain authorization for continuation of service.

Hospice Care

If an Enrollee requires hospice care, the PCP should contact Keystone First – CHIP's Utilization Management Department for prior authorization. Keystone First – CHIP will coordinate the necessary arrangements between the PCP and the hospice Provider in order to ensure receipt of Medically Necessary care.

Hospital Transfer Policy

When an Enrollee presents to the ER of a hospital ***not participating*** with Keystone First – CHIP ***and the Enrollee requires admission to a hospital***, Keystone First – CHIP may require that the Enrollee be stabilized and transferred to a Keystone First – CHIP participating hospital *for* ***admission*****.** When the medical condition of the Enrollee requires admission for stabilization, the Enrollee may be admitted, stabilized, and then transferred within twenty-four (24) hours of stabilization to the closest Keystone First – CHIP participating facility.

Elective inter-facility transfers must be prior authorized by Keystone First – CHIP's Utilization Management Department.

These steps must be followed by the Health Care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient
- Have an accepting physician in the receiving hospital

Either the sending or receiving facility may initiate the Prior Authorization; however, the original admitting facility will be able to provide the most accurate clinical information. Although not mandated, if a transfer request is made by a Keystone First – CHIP participating facility, the receiving facility may request the transferring facility obtain the Prior Authorization before the case will be accepted. When the original admitting facility has obtained the Prior Authorization, the receiving facility should contact Keystone First – CHIP to confirm the authorization, obtain the case reference number and provide the name of the attending Health Care Provider.

In emergency cases, notification of the transfer admission is required within forty-eight (48) hours or by the next business day (whichever is later) by the receiving hospital. Lack of timely notification may result in a denial of service.

Within 24 hours of notification of inpatient stay, the hospital must provide a comprehensive clinical review, initial assessment and plans for discharge.

Medical Supplies

Certain medical supplies are available with a valid prescription through Keystone First – CHIP's medical benefit, and are provided through durable medical equipment (DME) suppliers such as:

- Diabetic supplies. Please refer to the Keystone First – CHIP formulary for current preferred products and quantity limits.
    - Some continuous glucose monitor (CGMs) and supplies
    - Insulin, disposable insulin syringes and needles
    - Disposable blood and urine testing agents
    - Blood Glucose Meters
    - Lancets, control solution and strips
    - Glucose tablets, alcohol swabs

- Blood pressure monitors may be covered in Enrollees with certain comorbid medical conditions.
- Spacers are covered under Keystone First – CHIP's pharmacy benefit. Quantity limits are two per 365 days. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Peak flow meters (one per 365 days). Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- For current price and quantity limits, or to request school supply or replacement of a lost device that is covered under the Pharmacy benefit, contact Pharmacy Services at **1-844-779-2447.**

Newborn Care

Newborns remain in CHIP until a new eligibility determination is rendered.

It is the Enrollee's responsibility to call Keystone First – CHIP, the local County Assistance Office (CAO) or CHIP Statewide Change Center at **1-877-395-8930**, to assure newborn coverage, and determine future coverage as soon as the child is born.

Detained Newborns and Other Newborn Admissions

Facilities are generally required to notify Keystone First – CHIP of all newborn admissions, including, but not limited to, the following circumstances:

- Keystone First – CHIP regards a baby **detained** after the mother's discharge as a new admission. The admission must be reported to Keystone First – CHIP's Utilization Management Department within 24 hours and a new case reference number will be issued for the detained baby.
- Facilities are required to notify Keystone First – CHIP of all admissions to an **Intensive Care** or **Transitional Nursery** within 24 hours of the admission (even if the admission does not result in the baby being detained).
- Facilities are also required to notify Keystone First – CHIP of all newborn admissions where the payment under their contract will be at other than the newborn rate associated with APR-DRG 640X (even if the baby is not detained or admitted to an Intensive Care or Transitional Nursery).

To simplify the notification process and provide the best Utilization Management of our detained neonatal population, a special call center has been established to receive notifications 7 days a week, 24 hours a day.

Facilities should notify the Utilization Management Department Via phone, fax or the portal. When notifying Utilization Management of a detained baby or other newborn admission notifications, please be prepared to submit the following information:

- Mother's first and last name
- Mother's Keystone First – CHIP ID #
- Baby's first and last name

- Baby's date of birth (DOB)
- Baby's sex
- Admission date to Intensive Care/Transitional Nursery
- Baby's diagnosis
- First and last name of baby's attending practitioner
- Facility name and Keystone First – CHIP ID #
- Caller's name and complete phone number

Upon review and approval, a Utilization Management Coordinator will contact the facility and provide the authorization number assigned for the baby's extended stay or other admission. **All facility and associated practitioner charges should be billed referencing this authorization number.**

Keystone First – CHIP will pay detained newborn or other newborn admission charges according to established hospital-contracted rates or actual billed charges, whichever is less, for the bed-type assigned (e.g., NICU) commencing with the day the mother is discharged from the hospital. A new admission with a new case reference number will be assigned for the detained newborn or newborn admitted for other reasons. All detained baby or other newborn admission charges must be billed on a separate invoice.

Obstetrical/Gynecological Services

Direct Access

Female Enrollees may self-refer to a participating general OB/GYN Provider for routine OB/GYN visits. A referral from the Enrollee's PCP is not required.

Bright Start® Maternity Program Overview

Keystone First – CHIP offers a perinatal Care Management program, called the Bright Start Maternity Program, to pregnant Enrollees. The goal of the program is to reduce infant morbidity and mortality among Enrollees. The Bright Start Maternity Program is comprised of clinical and non-clinical staff who actively seek to identify pregnant Enrollees as early as possible in their pregnancy and continue to follow them through their post-delivery period.

Obstetrician's Role in Bright Start Maternity Program

OB Network Providers play a very important role in the success of the Bright Start Maternity Program, particularly the early identification of pregnant Enrollees to the Bright Start Maternity Program. OB Network Providers are responsible for:

- Following the American College of Obstetricians and Gynecologists (ACOG) standards of care for prenatal visits and testing
- Complying with Keystone First – CHIP protocols related to referrals, OB packages Prior Authorization, inpatient admissions, and laboratory services

- Allowing Enrollees to self- refer to their office for all visits related to routine OB/GYN care without a referral from their PCP.

For Keystone First – CHIP to successfully assist our pregnant Enrollees, we look to partner and collaborate with our Keystone First – CHIP OB Providers. For support, resources, or further information on the Bright Start Maternity Program, please contact the Bright Start Maternity Department at **1-800-521-6867**.

OB Network Providers are encouraged to refer mothers who smoke to the smoking cessation program. Additional information on the Smoking Cessation Program is in the Care Management Section of the Manual.

Health Care Providers may call Keystone First – CHIP's Enrollee Services Department at **1-844-524-2447** whenever they need help referring an Enrollee for behavioral health services.

Ophthalmology Services

Non-Routine Eye Care Services

When an Enrollee requires **non-routine** eye care services resulting from accidental injury or trauma to the eye(s), or treatment of eye diseases, Keystone First – CHIP will pay for such services through the medical benefit. The PCP should initiate appropriate referrals and/or authorizations for all non-routine eye care services.

See "**Vision Care**" in this section of this Manual for a description of Keystone First – CHIP's Routine eye care services. Keystone First – CHIP's routine eye care services are administered through Davis Vision. Routine eye exams and corrective lens Claims should not be submitted to Keystone First – CHIP for processing.

Questions concerning benefits available for Ophthalmology Services should be directed to the Provider Services Department at **1-800-521-6007**.

Outpatient Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our Enrollees, Keystone First – CHIP has made the following arrangements:

- Keystone First – CHIP encourages Network Providers to perform venipuncture in their office. Providers should then contact their assigned laboratory Provider* to arrange pick-up service
- Except for STAT laboratory services, Keystone First – CHIP requires that Network Providers utilize their assigned laboratory when outpatient laboratory studies are required for their Keystone First – CHIP Enrollees; failure to utilize the assigned laboratory may result in non-payment of laboratory claims.

STAT laboratory services are defined as laboratory services that require completion and reporting of results within four (4) hours of receipt of the specimen. A representative listing of STAT tests and their accompanying procedure codes is found in the Appendix to this Manual.

***PLEASE NOTE: ALL ENROLLEE ID CARDS IDENTIFY THE ASSIGNED LABORATORY**

The PCP is responsible for including all demographic information when submitting laboratory testing request forms.

Outpatient Renal Dialysis

Keystone First – CHIP does not require a referral or Prior Authorization for Renal Dialysis services rendered at Freestanding or Hospital-Based outpatient dialysis facilities. It is important to note Keystone First – CHIP's Epogen Policy for authorization procedures for doses **greater** than 50,000 units per month.

Free-Standing Facilities

The following services are payable without Prior Authorization or referrals for Free-Standing facilities:

- Training for Home Dialysis
- Back-up Dialysis Treatment
- Hemodialysis - In Center
- Home Rx for CAPD Dialysis (per day)
- Home Rx for CCPD Dialysis (per day)
- Home Treatment Hemodialysis (IPD)

Hospital Based Outpatient Dialysis

Keystone First – CHIP will reimburse Hospital Based Outpatient Dialysis facilities for all of the above services including certain lab tests and diagnostic studies that, according to Medicare guidelines, are billable above the Medicare composite rate. Please refer to Medicare Billing Guidelines for billable End Stage Renal Disease tests and diagnostic studies.

Associated Provider services (Nephrologist or other specialty provider) require a referral that must be initiated by the PCP. Once the treatment plan has been authorized, the specialty provider may "expand" the initial referral by contacting Keystone First – CHIP's Provider Services Department at **1-800-521-6007** and selecting prompt #4.

The following services require Prior Authorization through Keystone First – CHIP's Utilization Management Department:

- Supplies and equipment for home dialysis patients (Method II)
- Home care support services provided by an RN or LPN
- Transplants and transplant evaluations
- All inpatient dialysis procedures and services

Outpatient Testing

When a specialty provider determines that additional diagnostic or treatment procedures are required during an office visit, which has been previously authorized by the Enrollee's PCP, there is no further referral required.

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialty provider should note the Enrollee's information and procedures to be performed on his/her office prescription form. Refer to the **Prior Authorization Look Up Tool** on the Plan website.

When a patient presents to the hospital for any outpatient services not requiring a referral or Prior Authorization, he/she must bring a copy of the ordering Health Care Provider's prescription form.

Pediatric Preventive Care – Bright Futures

Keystone First – CHIP ensures that Bright Futures periodic screens are conducted for all eligible Enrollees to identify health and developmental problems.

These screens must be in accordance with the most current periodicity schedule and recommended pediatric immunization schedules based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC). The current schedule is posted on the website.

When appropriate, the Bright Futures Periodicity schedule, CMS, and CHIP policy requires that Keystone First – CHIP cover a maternal depression screen. Screening may be done in the PCP or pediatrician's office as part of the well-child visit and covered under the child's benefit when screening is for the direct benefit of the child. Validated screening tools such as the Edinburgh Postnatal Depression Scale or Post-Partum Depression Screening Scale are to be used. Coding for maternal depression screening performed as a preventative service as part of the well child visit incurs no copay or cost to the enrollee. CPT 96161 is to be used when coding for maternal depression screening under the child's CHIP benefit. ICD-10 codes that designate screening is done for the welfare of the child are to be used.

The Bright Futures Periodicity Schedule recommends screening at one, two, four, and six-month visits. Screening will be covered for infants under one year of age. Coding for maternal depression screening performed as a preventative service as part of the well child visit incurs no copay or cost to the enrollee. CPT 96161 is to be used when coding for maternal depression screening under the child's CHIP benefit. ICD-10 codes that designate screening is done for the welfare of the child are to be used. Pediatric preventive care must include blood lead levels testing of all children at ages one and two years old and for all children aged three through six without a confirmed prior lead blood test consistent with consistent with current PADOH and MA program requirements.

Pediatric preventive care must include blood lead levels testing of all children at ages one and two years old and for all children aged three through six without a confirmed prior lead blood test consistent with consistent with current PADOH and MA program requirements.

Lead Level Screening

The incidence of asymptomatic Undue Lead Absorption in children six (6) months to six (6) years of age is much higher than generally anticipated. The Centers for Medicare and Medicaid Services (CMS) and the Pennsylvania Department of Human Services have stringent requirements for Lead Toxicity Screening for all eligible children.

- **ALL** eligible children are considered at risk for lead toxicity and **MUST** receive blood lead level screening tests for lead poisoning
- PCPs are **REQUIRED (regardless of responses to the lead screening questions)** to make sure that children be screened for lead toxicity from **nine months to eighteen months and again from two to six years of age**
- Risk questions should be asked at every visit thereafter

PCPs should use venous blood samples for the blood level screening. To assist when that is not feasible, Keystone First – CHIP has contracted with MEDTOX Laboratories, to provide our contracted PCPs with supplies in order to conduct convenient in-office blood lead level screenings, via finger sticks, as well as the mailing supplies to return the samples back to MEDTOX for testing and processing. CMS policies require that all young children enrolled in CHIP be screened with a blood level test.

As an added incentive to help PCPs comply with these standards, Keystone First – CHIP will reimburse PCPs for blood lead screening services, if they are performed in the PCP's office. However, PCPs must utilize the MEDTOX process in order to receive this added payment.

Submit claim(s) with the following CPT codes for these services:

Billable Service	CPT Code	Fee
Lead Screening	83655	$10.00

Note: This service is only covered when the Department of Human Services guidelines are followed. Elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen.

Environmental Lead Testing

We cover all medically necessary blood level testing and related follow-up services for enrollees, in compliance with state (DHS/DOH) and federal regulations. If the enrollee has a high lead level (based on state guidelines), we will arrange for a professional home to find the source of the lead. We contract with Pennsylvania- certified lead investigators to ensure prompt access to environmental testing for enrollees across the state.

When an Environmental Lead Investigation (ELI) is conducted for an enrollee, we are responsible for ensuring the investigation results are:

Shared with the referring provider.
Communicated to the child's parent or legal guardian.
Reported to the Pennsylvania Department of Health and other relevant agencies, following all state and federal regulations.

Immunizations

Both State and Federal regulations request that immunizations be brought up to date during health screenings and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the Network Provider's records should show as much immunization history as can be elicited, especially the date of all previous immunizations. This will provide the necessary basis for further visits and immunizations.

The most up-to-date Childhood and Adolescent Immunization and catch-up schedule can be found on the Provider Center at www.keystonefirstchip.com.

Pharmacy Services

Pharmacy Services Phone Number:	**1-844-779-2447**
Pharmacy Services Fax Number:	**1-833-873-2908**
Enrollee Services Phone Number:	**1-844-472-2447**

The Keystone First – CHIP Pharmacy Services Department is responsible for all administrative, operational, and clinical service functions associated with providing Enrollees with a comprehensive pharmacy benefit.

All Enrollees have prescription benefits. There may be a co-payment associated with certain medications.

Keystone First – CHIP Enrollees do not have any copays for naloxone. When administered during an overdose, naloxone blocks the effects of opioids on the brain and restores breathing within two to eight minutes.

In general, Enrollees can receive up to a 34-day supply per prescription order or refill. Many medications are eligible to be filled for a 90-day supply as well.

Keystone First – CHIP has a proprietary retail pharmacy network to provide Enrollees a means to access their prescription drug benefit Keystone First – CHIP and our business partners work to

credential, communicate with and audit both independent and chain pharmacies providing products and services to our Enrollees.

Keystone First – CHIP's Drug Formulary

The Keystone First – CHIP's drug benefit has been developed with the Pennsylvania Department of Human Services to cover Medically Necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, Medically Necessary, and are not likely to result in adverse medical outcomes.

The Keystone First – CHIP Formulary and Prior Authorization process are key components of the benefit design. Medications are reviewed and approved by the Keystone First – CHIP's Pharmacy and Therapeutics Committee which includes physicians and pharmacists actively participating with Keystone First – CHIP as Network Providers, as well as consumer representatives or representatives designated to act on behalf of consumers. The goal of the Formulary is to provide clinically efficacious, safe and cost-effective pharmacologic therapies based on prospective, concurrent, and retrospective Drug Utilization Review as well as peer reviewed medical literature.

Keystone First – CHIP's Pharmacy and Therapeutics Committee meets regularly to review and revise the Formulary. Providers may request addition of a medication to the Formulary. Requests must include drug name, rationale for inclusion on the Formulary, role in therapy and Formulary medications that may be replaced by the addition. All requests should be forwarded in writing to:

PerformRx
P.O. Box 516
Essington, PA 19029

Please check for the most up-to-date printable Formulary that is available online in the Pharmacy section of our Provider Center website at **www.keystonefirstchip.com**.

Medication Covered by Other Insurance

Please refer to the Third-Party Liability section of this manual for complete details.

Pharmacy Prior Authorization Process

To Obtain Prior Authorization:
The Pharmacy Services Department at Keystone First – CHIP issues Prior Authorizations to allow processing of certain prescription Claims (more information on the types of drugs that require Prior Authorizations can be found later in this section) that would otherwise be rejected.

To contact the Pharmacy Services Department:

- Online:
  - **www.keystonefirstchip.com**
- By telephone:

  - **1-844-779-2447** between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST); and after business hours, Saturday, Sunday and Holidays,
  - The Enrollee Services Department at **1-844-472-2447**
- By fax: **1-833-873-2908**

The Prior Authorization procedure is as follows:

- Utilizing criteria approved by both Keystone First – CHIP's Pharmacy and Therapeutics Committee and DHS, (hereafter referred to as "Approved Criteria"), a Keystone First – CHIP pharmacist reviews the request
  - When the Prior Authorization request meets the Approved Criteria, the request is approved and payment for the prescription may be authorized for a period as designated in the applicable Approved Criteria, up to twelve months, or for the length of the prescriber's request, whichever is shorter
- In the event of insufficient information provided by the prescriber, a Keystone First – CHIP pharmacist will attempt to contact the prescriber to obtain the necessary clinical information for review. In addition, the decision will comply with the following statutory and regulatory requirements:
  - 55 Pa. Code 1121 (The Pennsylvania Code)
  - The Social Security Act
  - OBRA '90 guidelines
  - Any other applicable state and/or federal statutory/regulatory provisions

Requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Enrollee's condition or disease determines that the prescriber did not make a good faith effort to submit a complete request, or that the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

- When the Prior Authorization request does not meet the Approved Criteria, the request is forwarded to a Keystone First – CHIP Medical Director to review each request and make and communicate a determination within 24 hours of an urgent request, and within 2 business days but no more than 72 hours for non-urgent requests.
  - In evaluating the request, the Medical Director generally relies upon information supplied by the prescribers, the Medical Director's medical expertise, and accepted clinical practice guidelines.
- In the event of a denial, Keystone First – CHIP will notify the prescriber by fax, the PCP and the Enrollee by mail within 24 hours of an urgent request, and within 2 business days but no more than 72 hours for non-urgent requests. The correspondence will outline specifically all Enrollee and Health Care Provider Appeal rights, and if the requested drug is non-preferred/non-formulary and within the scope of the Keystone First – CHIP Formulary, Keystone First – CHIP will list preferred alternatives appropriate for the beneficiary's diagnosis and clinical condition. If the request is approved by the Medical Director, Keystone First – CHIP will notify the prescriber that the request has been approved.
- The prescriber or PCP may discuss Keystone First – CHIP's decision with a Keystone First – CHIP Clinical Pharmacist or Medical Director during regular business hours (Monday through Friday 8:30am- 6:00pm). For after- hours urgent calls, call the Enrollee

Services Department. To speak with a Keystone First – CHIP Clinical Pharmacist or Medical Director, please call the Pharmacy Services Department at **1-844-779-2447.**

- Prescribers and Enrollees may obtain Prior Authorization criteria related to a specific denial determination by submitting a written request for the criteria or by calling the Pharmacy Services Department.

To Request Ongoing Medication/Temporary Supplies:

If the request is for an ongoing medication, and the medication is covered, Keystone First – CHIP will automatically authorize a 15-day temporary supply of the requested medication at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the Enrollee to take. If the request is for a new medication and the medication is covered by the CHIP Program, a 5-day temporary supply of medication will automatically be authorized at the point-of-sale if Prior Authorization requirements do not allow the prescription to be filled upon presentation to the Pharmacy and if the pharmacist determines it safe for the Enrollee to take.

- Keystone First – CHIP may review requests for Prior Authorization when a temporary 5-day or 15-day supply has been dispensed regardless of whether the prescriber formally submits a Prior Authorization request. For those requests that are approved by a Keystone First – CHIP pharmacist, Keystone First – CHIP will contact the prescribing Provider by fax to inform him or her of the approval within 24 hours of the request's submission. The Provider informs the Enrollee of the approval.

Pharmacies have been made aware of the temporary supply requirements. If you become aware of a specific pharmacy that is not dispensing a temporary supply, please contact the Pharmacy Services Department at **1-844-779-2447.**

Drugs Requiring Prior Authorization

- All non-formulary medications
- All prescriptions that exceed plan limits
- All brand name medications with an available A-rated generic equivalent (see exceptions under Generic Medications below)
- Regimens that are outside the parameters of use approved by the FDA or accepted standards of care
- Early refills

Please note: additional drugs in the Formulary require Prior Authorization; consult the online Formulary for up-to-date Prior Authorization requirements. Medications without specific prior authorization criteria may be reviewed under other general criteria such as "Medications without Drug or Class Specific Criteria", "Quantity limit exception criteria", or others as applicable.

Injectable and Specialty Medications

Specialty Drug Program

Specialty drugs are a specific group of medications that include unusually high-cost oral, inhaled, injectable or infused pharmaceuticals. These drugs are typically prescribed for a relatively narrow spectrum of diseases and conditions and are drugs that often require specific distribution and/or handling. Specialty medications may include treatments covered under both the pharmacy benefit and the medical benefit. These products may have very specific clinical criteria and prescribing guidelines that must be followed to ensure appropriate use and outcomes. Compliance with these criteria is managed through the Prior Authorization process. Unless otherwise specified, specialty drugs managed by the Keystone First – CHIP Specialty Drug Program require Prior Authorization. Specialty drugs that are incidental to and administered during an inpatient hospital or hospital-based clinic stay are not managed through Keystone First – CHIP Specialty Drug Program and may not require Prior Authorization.

Health Care Providers should use specific forms that may be available for specialty and injectable medications online found on the pharmacy section of our website. The form must be completed in its entirety and faxed to the Keystone First – CHIP Specialty Drug Management Program at **1-833-873-2908**. Failure to submit all requested information could result in denial of coverage or a delay of approval as the result of insufficient information. Providers should inform Keystone First – CHIP Enrollees that specialty medications may not be available through a retail pharmacy and that designated specialty pharmacies should be utilized. **Specialty medications can be filled at any specialty pharmacy in the Keystone First – CHIP specialty network and should indicate the requested specialty pharmacy on all prior authorization forms.**

The pharmacy specialty network listing is available on the pharmacy pages on our website.

Enrollees can be directed to the Enrollee handbook and online for information about approved specialty pharmacies and a listing of specialty medications. Enrollees have the right to choose any network specialty pharmacy to provide medication and other ancillary services.

To speak to a Keystone First – CHIP representative about the Specialty Drug Management Program, please call **1-844-779-2447.**

Bleeding Disorders Management Program Description

Keystone First – CHIP has a comprehensive management program for Enrollees requiring authorization for blood factor products. The Bleeding Disorders Program includes Utilization Review, Care Management and Specialty Pharmacy Network Management for Enrollees with the following disorders/diseases: Hemophilia A and B, von Willebrand's Disease, Platelet Function Defects, as well as other rare deficiencies. The Clinical Prior Authorization Department reviews all requests for factor products administered in an Enrollee's home or in a Hemophilia Treatment Center in an effort to ensure appropriate dosing of factor, compliance, minimize product overstocking, and monitor utilization.

The Bleeding Disorders Nurse Care Manager works with the bleeding disorders population to:

- Provide support to Enrollees needing information and care regarding their disorder.
- Educates Enrollees and their families based upon recommendations provided by the Medical and Scientific Advisory Council (MASAC) through the National Hemophilia Foundation (NHF).
- Coordinates services for health care issues, by working with PCPs and other Providers to ensure Enrollees get timely needed care.
- Locates community resources; and function as a liaison between the Enrollee, the specialty pharmacy Network, and the hemophilia treatment center/Provider.
- Communicates with the Enrollee's treating physician (and the Primary Care Physician if appropriate) when complications are identified that require intervention outside of the scope of the Bleeding Disorders Nurse Care Manager and documents these interactions accordingly in the appropriate system.
- Identifies problems/barriers to Keystone First – CHIP's Care Coordination Team for appropriate care management interventions.
- Assists the Enrollee in resolving care issues and/or barriers to services including, but not limited to pharmacy, equipment, PCP and specialty provider physician access, outpatient services, home health care services and coordination of transportation for medical appointments.
- Is responsible for regular telephone contact with the Enrollee and/or treatment team.
- Aligns its goals and objectives with those of the Hemophilia Treatment Centers (HTC) to ensure continuity and acuity of care.
- Is available 24/7 to Specialty Pharmacies Treating Physician/HTC's and Enrollees if needed.
- Ensure that factor dosage, and days of service are accurate.
- Review the previous month to compare and ensure the new request is accurate.

The Care Manager applies the seven domains that represent the essential information that a Case Managers must know:

- Care Management Concepts
- Principles of Practice
- Healthcare Management and Delivery
- Healthcare Reimbursement
- Psychosocial Aspects of Client's Care
- Rehabilitation
- Professional Development and Advancement

The Procedure for Requesting Hemophilia Medications is as follows:

Completed Prior Authorization request form (including current weight). Forms are available on the pharmacy prior authorization section of the website.

- Physician order/prescription (needed with every request)
- Administration/Bleed logs if available
- The Provider must submit a completed hemophilia factor order request form and a prescription from the doctor for all initial factor requests.
- If a Provider coordinates directly with a Specialty Pharmacy for request submission, the
- Specialty Pharmacy sends the request to PerformRx for review.
- Bleeding Disorder Nurse Case Manager Reviews and authorizes factor.
- Specialty Pharmacy timely delivers factor via UPS or another carrier.

All subsequent requests for refills require a completed hemophilia factor order form, a copy of the physician's current prescription, and the Enrollee's Administration/Bleed log in order to determine the appropriate amount of medication to be replaced.

Blood factor products that are subject to review include Factor VII (Novoseven), Factor VIII, Factor IX, Factor FXIII and Anti-Inhibitor Coagulant Complex as well as the monoclonal antibody Hemlibra and any other products as per requirements of the Keystone First – CHIP Formulary. Medication may be approved on an as needed basis for patients requiring replacement medication or for treatment of episodic bleeding. Delivery of approved products to Enrollees is coordinated via authorized Specialty Pharmacy Providers.

Bleeding Disorder Program Contact: **PerformRxBleedingDisorders@performrx.com**

Generic Medications

The use of generic drugs in place of brand name products is mandated by the Commonwealth of Pennsylvania when the brand name product has an FDA approved A-rated generic equivalent available. When an approved generic equivalent is available, all prescriptions denoting "Brand Necessary" require Prior Authorization. Some exceptions may apply if a brand name formulation has been designated as preferred on the Keystone First – CHIP Formulary PDL.

A Health Care Provider requesting a brand product that requires prior authorization must include information to substantiate medical necessity for a brand medication, such as documentation of adverse effects of generic alternatives. For specific details, refer to the Pharmacy Prior Authorization Process section of the manual.

A limited number of brand name products that have generic equivalents may also be excluded from the above Prior Authorization requirement. These include some medications with a Narrow Therapeutic Index (NTI).

Over-the-Counter Medication

Select over-the-counter medications are covered by Keystone First – CHIP with a prescription from the prescribing Health Care Provider if mandated by the Affordable Care Act or specifically covered under the formulary.

Covered over-the-counter medications can be found within the online formulary at **www.keystonefirstchip.com**

Diabetic Testing Supplies

Diabetic testing supplies are subject to the Keystone First – CHIP Formulary.

Please refer to the online formulary on the Pharmacy section of our website at www.keystonefirstchip.com

For ALL other DME and medical supplies including diapers and diabetic supplies, please refer to the Durable Medical Equipment and Medical Supplies section of this Manual.

Non-Covered Medications

The following are non-covered medications and therefore not covered by Keystone First – CHIP, unless otherwise specified:

- Drugs for hair growth or other cosmetic purposes
- Drugs that promote fertility
- Non-legend drugs in the form of troches, lozenges, throat tablets, cough drops, chewing gum, mouthwashes, and similar items with the exception of products for tobacco cessation
- Pharmaceutical services provided to a hospitalized person
- Drugs and devices classified as experimental by the FDA or not approved by the FDA
- Placebos
- Non-legend soaps, cleansing agents, dentifrices, mouthwashes, douche solutions, diluents, ear wax removal agents, deodorants, liniments, antiseptics, irrigants, and other personal care and medicine chest items
- Non-legend aqueous saline solution
- Non-legend water preparations
- Non-legend drugs not covered by the CHIP Program
- Items prescribed or ordered by a Health Care Provider who has been barred or suspended from participating in the MA Program
- DESI drugs and identical, similar or related products or combinations of these products
- Legend or non-legend drugs when the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Prescriptions or orders filled by a pharmacy other than the one to which a recipient has been restricted because of improper utilization or abuse
- Non-legend impregnated gauze and any identical, similar, or related non-legend products
- Any pharmaceutical product marketed by a drug company which has not entered into a rebate agreement with the Federal Government as provided under Section 4401 of the Omnibus Reconciliation Act of 1990
- Drugs prescribed for the treatment of Sexual or Erectile Dysfunction (ED)

Podiatry Services

Keystone First – CHIP Enrollees are eligible for all Medically Necessary podiatry services, including x-rays, with a referral written by the PCP to a podiatrist in the Network. It is recommended that the PCP use discretion in referring Enrollees for routine care such as nail clippings and callus removal, taking into consideration the Enrollee's current medical condition and the medical necessity of the podiatric services.

Podiatry Services/Orthotics

Network Providers may dispense any Medically Necessary orthotic device compensable under the CHIP Program upon receiving Prior Authorization from the Keystone First – CHIP's Utilization Management Department. Questions regarding an item should be directed to Keystone First – CHIP's Provider Services Department at **1-800-521-6007**.

Provider Preventable Conditions Payment Policy

Keystone First – CHIP's payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is Keystone First – CHIP's policy to deny payment for PPCs.

Other Provider-Preventable Conditions (OPPC) is more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting that: (i) is identified in the Commonwealth of Pennsylvania State Medicaid Plan; (ii) has been found by the Commonwealth to be reasonably preventable through application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the Enrollee; (iv) can be discovered through an audit; and (v) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs (surgery on the wrong patient, wrong surgery on a patient and wrong site surgery).

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payors to make ***pre-payment*** adjustments. That is, a PPC must be reported by the Provider at the time a claim is submitted.

There are some circumstances under which a PPC adjustment will not be taken or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting a Present on Admission section for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and Keystone First – CHIP can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

Practitioner/Dental Providers

- If a PPC occurs, Providers must report the condition through the claims submission process. Note that this is required even if the Provider does not intend to submit a claim for reimbursement for the services. The requirement applies to Providers submitting claims on the CMS-1500 or 837-P forms, as well as and dental Providers billing via ADA claim form or 837D formats.

For professional service claims, please use the following claim type and format:

Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D of the CMS 1500 claim form.
- Dental Providers must report a PPC on the paper ADA claim form using modifier PA, PB or PC on the claim line, or report modifiers PA, PB or PC in the remarks section or claim note of a dental claim form.

Claim Format:

- Report the E diagnosis codes, such as Y65.51, Y65.52 or Y65.3 in field 21 [and/or] field 24E of the CMS 1500 claim form.

Inpatient/Outpatient Facilities

- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the Provider does not intend to submit a claim for reimbursement of the services. This requirement applies to Providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.** When submitting a claim which includes treatment as a result of a PPC, facility Providers are to include the appropriate ICD10diagnosis codes, including applicable external cause of injury codes on the claim in field 67 A – Q. Examples of ICD-10 and diagnosis codes include:

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52;
- Surgery on wrong site Y65.3
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

For per-diem or percent of charge-based hospital contracts, claims including a PPC must be submitted via paper claim with the patient’s medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

All information, including the patient's medical record and paper claim should be sent to:

Medical Claim Review
c/o Keystone First – CHIP
P.O. Box 211396
Eagan, MN 55121

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

For Outpatient Providers
Outpatient facility Providers submitting a claim that includes treatment required because of a PPC must include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury codes on the claim in field 67 A – Q. Examples of ICD-10 and diagnosis codes include:

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52; and
- Surgery on wrong site Y65.53.

Reporting a Present on Admission PPC
If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG based facilities may submit POA via 837I in loop 2300; segment K3, data element K301.

Valid POA indicators are as follows:
"Y" = Yes = present at the time of inpatient admission
"N" = No = not present at the time of inpatient admission
"U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
"W" = Clinically Undetermined = Provider is unable to clinically determine whether condition was present at time of inpatient admission or not
"null" = Exempt from POA reporting.

Radiology Services

The following services, when performed as an **outpatient service**, require prior authorization by Keystone First – CHIP's radiology benefits vendor, Evolent.

- Positron Emission Tomography (PET)
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
- Nuclear Cardiology /MPI
- Computed Axial Tomography (CT/CTA/CCTA)

To request prior authorization, contact Keystone First – CHIP's radiology benefits vendor (Evolent via their Provider web-portal at www1.radmd.com or by calling 1-800-424-1779 Monday through Friday 8 a.m. –8 p.m. (EST).

The ordering physician is responsible for obtaining a Prior Authorization number for the requested radiology service. Patient symptoms, past clinical history and prior treatment information will be requested by Evolent and the ordering physician should have this information available at the time of the call.

Weekend, Holidays and After-Hours Requests*
Requests can be submitted online at **www1.radmd.com** – The Evolent web site is available 24 hours a day to Providers.

Weekend, holiday, and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to Evolent and a message may be left (**1-800-424-1779**), which will be retrieved the following business day.
Requests left on voice mail:

- Evolent will contact the requesting Provider's office within one business day of retrieval of the voice mail request to obtain necessary demographic and clinical information to process the request.

**** Evolent's hours are 8:00 a.m. – 8:00 p.m. Eastern time, Monday through Friday, excluding holidays***

Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.

Rehabilitation

If an Enrollee requires extended care in a non-hospital facility for rehabilitation purposes, Keystone First – CHIP's Utilization Management Department will review request for inpatient rehabilitation for medical necessity and level of care. All inpatient rehabilitation requests require prior authorization.

Reporting Communicable and Noncommunicable Disease
All cases of reportable communicable disease that are detected or suspected in a Keystone First – CHIP Enrollee either by a clinician or a laboratory must be reported to the Pennsylvania Department of Health (DOH) as required by 28 PA Code, Chapter 27. The full text of these rules can be found at: **Communicable and Noncommunicable Diseases (Chapter 27)**.

Termination of Pregnancy

First and second trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:

1. The Enrollee's life is endangered if she were to carry the pregnancy to term; or

2. The pregnancy is the result of an act of rape or incest.

Life Threat
When termination of pregnancy is necessary to avert a threat to the Enrollee's life, a physician must certify in writing and document in the Enrollee's record that the life of the Enrollee would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the Enrollee's life is endangered is a medical judgment to be made by the Enrollee's physician. This certification must be made on the **Pennsylvania Department of Human Service's Physician's Certification for an Abortion** (MA 3 form) (see Appendix for sample). The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by Keystone First – CHIP. If the Enrollee is under the age of 18, a Recipient Statement Form (MA368) must be completed and submitted.

Rape or Incest
When termination of pregnancy is necessary because the Enrollee was a victim of an act of rape or incest the following requirements must be met:

- Using the **Pennsylvania Department of Human Service's Physician's Certification for an Abortion (MA 3 form) (see Appendix for sample form),** the physician must certify in writing that:
    - In the physician's professional judgment, the Enrollee was too physically or psychologically incapacitated to report the rape or incest to a law enforcement official or child protective services within the required timeframes (within 72 hours of the occurrence of a rape or, in the case of incest, within 72 hours of being advised by a physician that she is pregnant); or
    - The Enrollee certified that she reported the rape or incest to law enforcement authorities or child protective services within the required timeframes
- Using the **Pennsylvania Department of Human Service's Recipient Statement Form (MA 368 or MA 369 form) (see Appendix for sample form),** the physician must obtain the Enrollee's written certification that the pregnancy is a result of an act of rape or incest and:
    - the Enrollee did not report the crime to law enforcement authorities or child protective services; or
    - the Enrollee reported the crime to law enforcement authorities or child protective services

- The **Pennsylvania Department of Human Service's Physician's Certification for an Abortion** and the **Pennsylvania Department of Human Service's Recipient Statement Form** must accompany the claim for reimbursement. The **Physician's Certification for an Abortion** and **Recipient Statement Form** must be submitted in accordance with the instructions on the certification/form. The claim form, **Physician's Certification for an Abortion**, and **Recipient Statement Form** will be retained by Keystone First – CHIP**.**

Vision Care

Vision Benefit Administrator

Keystone First – CHIP's routine vision benefit is administered through Davis Vision. Inquiries regarding routine eye care and eyewear should be directed to the Davis Vision Provider Relations Department at **1-800-773-2847** or you may want to visit the Web site at **www.davisvision.com**. Practitioners who are not part of the vision Network can call Davis Vision's Professional Affairs Department at **1-800-933-9371** for general inquiries. Medical treatment of eye disease is covered directly by Keystone First – CHIP. These inquiries should be directed to Keystone First – CHIP's Provider Services Department at **1-800-521-6007**.

Eye Examinations

- All routine eye examinations must be performed by a participating provider. There is no coverage when performed by a nonparticipating provider.*
- A routine eye examination and refraction, including dilation if professionally indicated, is **covered 100%, once (1) every calendar year**.

Frames and Prescription Lenses

- One (1) pair of frames every calendar year at no additional cost, when purchased from a participating provider and selected from the standard collection of frames.
- For frames that are not part of the standard collection of frames, expenses over $130 are the Enrollee's responsibility. Additionally, a 10% frame discount applies to any amount over $130.
- One (1) set of prescription eyeglass lenses every calendar year that may be plastic or glass*, single vision, bifocal, trifocal, lenticular and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, and polycarbonate prescription lenses.
- All prescription lenses include scratch-resistant coating.
- There is no copayment for standard prescription eyeglass lenses with a scratch-resistant coating. However, most optional lens types and treatments have applicable copayments.
- Replacement of lost, stolen, or broken frames and prescription lenses, when deemed medically necessary, once every calendar year.*

Prescription Contact Lenses

- One (1) prescription contact lens benefit every calendar year, in place of eyeglasses or when medically necessary, must be purchased from a participating provider.
- Expenses over $130, which may be applied toward the cost of evaluation, materials, fitting and follow-up care, are the Member's responsibility. Additionally, a 10% discount applies to any amount over $130.
- In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care related to contact lenses. Should this occur, and the

value of the prescription contact lenses received is less than the allowance, the remaining balance can be applied to the total $130 allowance.

- Expenses in excess of $600 for medically necessary prescription contact lenses, and with preapproval, may be obtained for conditions including:
    - aphakia;
    - pseudophakia;
    - keratoconus;
    - if the patient has had cataract surgery or implant, or corneal transplant surgery; or if visual activity is not correctable to 20/40 in the worse eye by use of eyeglass lenses, but can be to 20/40 in the worse eye by use of contact lenses.
    - Replacement of lost, stolen, or broken prescription contact lenses, when deemed medically necessary, once every calendar year.*

Low Vision Benefits
One (1) comprehensive low vision evaluation every five (5) years, with a maximum charge of $300; maximum low vision aid allowance of $600, with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care—four (4) visits in any five (5)-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary preauthorization for these services.
Keystone First – CHIP recognizes that optometrists are able to provide all services within the scope of their practice that are covered by the Pennsylvania Medical Assistance program, including benefit limits, category of aid restrictions as determined by Keystone First – CHIP. Optometrists may provide the following services:

- Evaluation and Management services
- General Optometry services (eye exams)
- The administration and prescription of drugs approved by the Secretary of Health

* A participating provider must be used for these services.

Please note that Enrollees may self-refer for two routine eye exam per year. Keystone First – CHIP covers therapeutic optometry services through Davis Vision (unless the optometrist is in an Ophthalmology group that bills through the Keystone First – CHIP claims process). Contact Davis Vision at **1-800-773-2847** for questions regarding covered services and prior authorization requirements.

Section III
Enrollee Eligibility

Enrollment Process

Keystone First – CHIP is informed on a daily basis of eligible recipients who have selected Keystone First – CHIP as their insurance provider. The Enrollee is assigned an effective date by DHS.

Keystone First – CHIP Identification Card

The Keystone First – CHIP Identification Card lists the following information:

- Enrollee's Name
- Keystone First – CHIP Identification Number with a 3-digit alpha prefix
- Enrollee's Date of Birth
- PCP'S Name and Phone Number
- Lab Name
- Select Co-pays
- The ID Card includes a three-digit alpha prefix "to the Enrollee ID number. This 3-digit alpha prefix merely indicates that this is a program under Keystone First CHIP. Please omit the alpha prefix when submitting all paper and electronic Claims, as well as when inquiring about Enrollee's eligibility and/or Claims status telephonically at **1-800-521-6007**.

To see the current Keystone First - CHIP Identification Card template, please visit www.keystonefirstchip.com → Enrollees → Getting Care → ID Cards.

Continuing Care

Enrollees are allowed to continue ongoing treatment with a Health Care Provider who is not in the Keystone First – CHIP Network when any of the following occur:

- A new Keystone First – CHIP Enrollee is receiving ongoing treatment from a Health Care Provider who is not in the Keystone First – CHIP Network
- A current Keystone First – CHIP Enrollee is receiving ongoing treatment from a Health Care Provider whose contract has ended with Keystone First – CHIP for reasons that are "not-for-cause"

An Enrollee is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve months the Enrollee was treated by the Provider for a condition that requires follow-up care or additional treatment, or the services have been Prior Authorized.

- Any child (under the age of 19) with a previously scheduled appointment, including an appointment for well childcare, shall be determined to be in receipt of an ongoing course of treatment from the Provider.

Keystone First – CHIP allows:

Newly Enrolled Enrollees to receive ongoing treatment from a Health Care Provider who is not in the Keystone First – CHIP Network for up to 60 days from the date the Enrollee is enrolled in Keystone First – CHIP.

Newly Enrolled Enrollees who are pregnant on the effective date of Enrollment to receive ongoing treatment from an Obstetrician (OB) or midwife who is not in the Keystone First – CHIP Network through the completion of postpartum care related to the delivery.

Current Enrollees who are receiving treatment from a Health Care Provider (physician, midwife or CRNP) whose contract with Keystone First – CHIP has ended, to receive treatment for up to 60 days from the date the Enrollee is notified by Keystone First – CHIP that the Health Care Provider will no longer be in the Keystone First – CHIP Network or for up to 60 days from the date the Provider's contract with Keystone First – CHIP ends – whichever is longer.

Current Enrollees receiving ongoing treatment from a Network Provider other than a physician, midwife or CRNP, such as a health care facility or health care agency whose contract has ended with Keystone First – CHIP, to receive treatment for up to 60 days from the date Keystone First – CHIP notifies the Enrollee that the health care Provider will no longer be in the Keystone First – CHIP network, or for up to 60 days from the date the Provider's contract with Keystone First – CHIP ends – whichever is longer.

Current Enrollees in their second or third trimester receiving ongoing treatment from an OB or midwife whose contract with Keystone First – CHIP has ended with Keystone First – CHIP to continue treatment from that OB or midwife until the end of her postpartum care related to the delivery.

Ongoing treatment or services are reviewed on a case-by-case basis and include but are not limited to pre-service or follow-up care related to a procedure or service and/or services that are part of a current course of treatment. If an Enrollee wants to continue treatment or services with a Health Care Provider who is not in the Keystone First – CHIP Network: (1) the Health Care Provider must contact Keystone First – CHIP's Utilization Management Department via phone, fax, or provider portal; or (2) the Enrollee must contact Enrollee Services at **1-844-472-2447**.

Once Keystone First – CHIP receives a request to continue care, the Enrollee's case will be reviewed. Keystone First – CHIP will inform the Health Care Provider and the Enrollee by telephone whether continued services have been authorized. If for some reason continued care is not approved, the Health Care Provider and the Enrollee will receive a telephone call and a letter that includes Keystone First – CHIP's decision and information about the Enrollee's right to appeal the decision.

The Health Care Provider must receive approval from Keystone First – CHIP to continue care.

Keystone First – CHIP will not cover continuing care with a Health Care Provider whose contract has ended due to quality of care issues or who is not compliant with regulatory requirements or contract requirements, or if the Provider is not enrolled in the CHIP program.

Verifying Eligibility

Each Network Provider is responsible to ascertain an Enrollee's eligibility with Keystone First – CHIP before providing services.

Keystone First – CHIP shall use its best efforts to have the coverage become effective on the first day of the calendar month following the month in which a determination of eligibility is made. In no case shall the effective date of coverage be delayed beyond the first day of the second calendar month following the month in which a determination of eligibility is made. In the case where a child is Low-Cost or Full-Cost eligible, the child is placed in an Alien Certification of Registry (ACR) status pending receipt of payment. The child is enrolled for the processing date for which money was received within 60 days from the determination of eligibility.

Verification of eligibility consists of a few simple steps; they are:

- As a first step, all Providers should ask to see the Enrollee's Keystone First – CHIP Identification Card It is important to note that Keystone First – CHIP ID cards are not dated and do not need to be returned to Keystone First – CHIP should the Enrollee lose eligibility. Therefore, a card itself does not indicate a person is currently enrolled with Keystone First – CHIP.

Since a card alone does not verify that a person is currently enrolled in Keystone First – CHIP, it is critical to verify eligibility through any of the following methods:

1. **Internet:** NaviNet (**www.navinet.net**).
    - This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to Keystone First – CHIP.
    - For more information or to sign up for access to NaviNet visit the Provider Center at **www.keystonefirstchip.com** **or** **www.navinet.net** **or call NaviNet Customer Service at 1-888-482-8057**

2. **Keystone First – CHIP's Automated Eligibility Hotline 1-800-521-6007:**
    - Provides immediate real-time eligibility status with no holding to speak to a representative.
    - Call the Automated Eligibility Hotline 24 hours/7 days a week, at **1-800-521-6007**:
        - **i.** Verify an Enrollee's coverage with Keystone First – CHIP by their Keystone First – CHIP identification number, Social Security Number, name, birth date or CHIP Identification Number
        - **ii.** Obtain the name and phone number of the Enrollee's PCP

3. **PROMISe**
    - Visit **https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx** and click on PROMISe Online

Monthly Panel List

Below is an example of the monthly panel list that is available on NaviNet at **www.navinet.net.** It is important to check panel rosters routinely to review Enrollees who are missing important services, such as Bright Future screenings and preventative care visits.

Note: All Enrollees are assigned a PCP. As a reminder, it is critical to check Enrollee eligibility prior to the visit (please refer to the Enrollee Eligibility section for the methods available).

Keystone First – CHIP Sample Panel List
All information on this sample is fictitious

1	2	3	4	5	6	7	8	9	10	11	12	13	15
Enrollee ID#	**Recipient#**	**DOB**	**Name**	**Address**	**Phone**	**Age**	**Gender**	**Other Ins**	**Date Eff On Panel**	**V***	**Provider Name/No**	**N***	**Language**
11111111	1010101010	5/2/2002	Abdul, Abba	2323 Warren St Phila PA 19100	215-999-9999	3m	M		5/2/2002		J Brown 11223344	Y	English
53333333	4030303030	2/1/1975	Abdul, Geraldine	414 Narth Ave Phila, PA 19100	215-999-9999	27	F		2/1/2001		R Kelly 1156677		
37777777	6070707070	8/31/1986	Absent, Carol	8787 Cookie Ln Phila, PA	215-999-9999	15	F		6/1/2001		B Hamster 11777577		
84444444	7040404040	6/12/1990	Amber, Diane	3535 Creig St Phila, PA 19182	215-999-9999	49	M	Y	1/1/2000	Y	J Brown 1122334		
95555555	5050505050	10/5/1949	Bratt Esther	30 Wonder Rd Phila, PA 19181	215-777-7777	61	F	Y	7/1/1999		B Hamster 1122110	Y	
50000000	6060606060	3/16/1967	Download, Darren	55 Blank St Phila, PA	215-222-2222	58	M		3/1/1997	Y	M Weinbert 1177558		
62000000	3060606060	4/21/1996	Candy, Frank	251 Bleak Rd Phila, PA 19179	215-444-4444	6	F		8/12/02		J Brown 11223344	Y	

Panel Count = 7

1. Keystone First – CHIP Identification Number
2. Enrollee's Assistance Recipient Number
3. Enrollee's date of Birth
4. Enrollee's Name
5. Enrollee's Address
6. Enrollee's Phone Number
7. Enrollee's Age
8. Enrollee's Gender
9. Enrollee's Other Insurance
10. Enrollee's Effective Date with PCP
11. V* = Was Enrollee Seen Within Last 6 Months
12. Enrollee's Assigned PCP
13. N* = New Enrollee to PCP
14. Enrollee's preferred language

Section IV
Provider Services

NaviNet

Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks – patient care. NaviNet is a "one-stop" service that supports your office's clinical, financial and administrative needs**.** If you are not already a NaviNet user, it is simple to start the process.

Log on to **www.navinet.net** to register or call **1-888-482-8057** to speak to NaviNet Customer Service.

NaviNet Supports Pre-Visit Functions

- **Eligibility and Benefits Inquiry**
  - ✓ Real-time access to Enrollee eligibility and benefits
- **Care Gaps**
  - ✓ A summary of the age/sex/condition appropriate health screens that an Enrollee should have

    Care Gap Alerts*
    - Care Gap notification that appears when checking Enrollee eligibility
    - View and print for Enrollees coming into your office. Place them with the patient's medical chart so they can be addressed during the visit.

    Care Gap Reports*
    - Customizable reports that can be used to target at risk Enrollees
    - Can be downloaded and faxed back to Keystone First – CHIP with updated information

- **Enrollee Clinical Summary***

  ✓ A virtual snapshot of a patient's relevant clinical facts and demographic information in a user-friendly format. Enrollee clinical summaries enable your practice to secure a more complete view of established patients and provide valuable information on new patients.

  ✓ The summary can be exported into EMR systems (CCD format). Enrollee Clinical Summaries include information, such as:
  - Demographic information
  - Chronic conditions
  - ER Visits (within the past 6 months)
  - Observation stays
  - Inpatient Admissions (within the past 12 months)
  - Medications (within the past 6 months)
  - Office Visits (within the past 12 months)
  - Imaging Services
  - Lab Data

**Note: Your NaviNet Security Administrator will need to turn on access to this information for designated users in their NaviNet security profile, as this summary contains extensive personal health information.*

NaviNet Supports Patient/Provider Visits

- **Care Gaps (see Pre-Visit section above)**
  - ✓ Use the care gap reports to provide your patients with appropriate and needed health screenings
  - ✓ Maximize your opportunity for incentive dollars
- **Enrollee Clinical Summary (see Pre-Visit section above)**

Prior Authorization Submission through Medical Authorizations via the NaviNet Provider Portal. For detailed information, Frequently Asked Questions and training materials, visit Keystone First – CHIP Plan Central on NaviNet.

Access Medical Authorizations, a streamlined online authorization workflow:

- Submit an Authorization
- Submit an amended authorization
- Verify if no authorization is required
- Inquire on existing authorization
- Attach supplemental documentation
- Sign up for in-app status change notifications directly from the health plan
- Access an authorization log
- Medical Authorizations Video tutorials and user guide are available on the NaviNet Plan Central Home Page

NaviNet Supports Claims Management Functions

- NaviNet functionality allows your practice to:
  - ✓ Check the status of submitted claims
  - ✓ View claim EOBs
  - ✓ Perform claim adjustments

NaviNet Supports Back Office Functions

- **Panel Roster**
  - Provides easy and immediate access
  - Contains panel report plus historical reports for the past six months
  - Reports can be imported into Excel for sorting and/or mailing to targeted patients
  - Reports can be integrated with your practice management system

Navinet Disputes Submission

Keystone First – CHIP providers may submit disputes related to claim issues and upload supporting documentation through the NaviNet provider portal.
This functionality allows providers to electronically submit disputes and associated documentation, reducing the need for phone calls, mailed requests, or faxed materials.

Dispute Submission Process

1. Access Forms and Dashboards within the NaviNet provider portal
2. Select and complete the applicable dispute submission form
3. Upload required supporting documentation
4. Submit the completed form

Upon submission, a document ID number will be provided. This document ID number will need to be included in any follow-up inquiries.

Supporting Documentation Requirements

- There is no limit on the number of supporting documents that can be uploaded when submitting a request.
- Each Document must be 32 MB or smaller
- Accepted file formats include: • .docx, .doc • .pdf • .png • .jpg • .xls, .xlsx

Navinet Claims Investigation Attachments

Providers may upload supporting documentation when submitting an electronic Claim Investigation request through the NaviNet provider portal. This functionality allows documentation to be submitted electronically at the time of request, eliminating the need to fax or mail materials.

Submission of Supporting Documentation

When submitting a Claim Investigation request in NaviNet, providers may attach relevant supporting documents directly within the portal.

This process eliminates the need to:

- Complete separate paper forms
- Fax or mail supporting documentation

Documentation Requirements

- Each Document must be 32 MB or smaller
- Accepted file formats include: .docx, .pdf, .png, .gif

Training and Resources

Providers who are new to the Claim Investigation process in NaviNet may view the Claims Investigation training video available within the portal for step-by- step walkthrough of submission process.

EDI Technical Support Hotline

Keystone First – CHIP has an EDI Technical Support Unit within the Information Solutions Department to handle the application, set-up and testing processes for electronic Claim submission. Please call the toll-free EDI Hotline at **1-877-234-4271** with any EDI inquiries, questions, and/or electronic billing concerns. More detailed information is available in the Claims Filing Instructions at **www.keystonefirstchip.com**.

Some benefits of electronic billing include:

- Faster transaction time for Claims
- Reduction in data entry errors on Claims processed
- The ability to receive electronic reports showing receipt of Claims by the insurance plan

Keystone First – CHIP's Payor ID is 30070

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

EFT simplifies the payment process by:

- Providing fast, easy and secure payments
- Reducing paper
- Eliminating checks lost in the mail
- Not requiring you to change your preferred banking partner

Enroll through our EFT partner, ECHO Health. For detailed information and instructions log on to **www.keystonefirstchip.com** or call **1-888-834-3511.**

ERA – Call ECHO Health customer service to sign up for electronic remittance advice: **1-888-471-3920**

Provider Claims Service Unit

The Provider Claim Services Unit (PCSU) is a specialized unit of the Claims Department. This unit assists Providers with payment discrepancies and makes on-line adjustments to incorrectly processed Claims.

Some of the Claims-related services include:

- Review of Claim status (Note: Claim status inquiries can also be done online at **www.navinet.net**)
- Research on authorization, eligibility and coordination of benefits (COB) issues related to Denied Claims
- Clarification of payment discrepancies
- Adjustment(s) to incorrectly processed Claims
- Assistance in reading remark, denial and adjustment codes from the Remittance Advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures

- Explanation of referral and authorization issues related to Claim payment
- Information on billing and Claim requirements
- Assistance in obtaining individual Network Provider numbers for Network Providers new to an existing Keystone First – CHIP group practice

Call the Provider Claim Services Unit at **1-800-521-6007** as the first point of contact to resolve claims issues. For claims issues that can't be resolved through Provider Claims Services, contact your Provider Account Executive.

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider Network for Enrollees. Contracting staff is responsible for negotiating contracts with hospitals, physicians, ancillary, DME and other Providers to assure our Network can treat the full range of CHIP covered benefits in an accessible manner for our Enrollees.

The primary contact for Network Providers with Keystone First – CHIP should be through **Provider Services (1-800-521-6007).** For any issues that cannot be resolved through standard operating departments, the Provider's assigned Provider Account Executive would be the appropriate contact. Provider Account Executives are responsible for orientation, continuing education, and diplomatic problem resolution for all Network Providers. A Provider Account Executive will act as your liaison with Keystone First – CHIP. Provider Account Executives visit Network Provider locations to conduct in-service/orientation meetings with Network Providers and their staff both pro-actively and in response to Network Provider issues involving policy and procedure, reimbursement, compliance, etc.

A complete list of Account Executive territory assignments and contact numbers is available on the Provider Center under Contact Us at **www.keystonefirstchip.com**.

Provider Account Executives also perform an ADA site visit, practice environment evaluation and review medical record keeping practices of PCPs and OB/GYNs who are joining the network. *Provider Network Management will conduct a site visit and medical record keeping review for all PCP, OB/GYN, general and pediatric dentists applying to participate in the network. Scores for these reviews must be 85% or greater.

Provider Network Management, in collaboration with the Utilization Management Department, negotiates rates for Non-Participating Providers and facilities when services have been determined to be Medically Necessary and are Prior Authorized by Keystone First – CHIP.

Contact your Provider Account Executive**:**

- To arrange for orientation or in-service meetings for Network Providers or staff
- To request an appointment/dedicated time with your Account Executive
- To report any changes in your status, e.g.:
    - Phone number
    - Address
    - Tax ID Number
    - Additions/deletions of physicians affiliated with your practice

Network Providers should contact their Provider Account Executive or Provider Services with changes to their demographic information. Network Providers may verify their demographic data at any time using the "real-time" Provider Network directory at **www.keystonefirstchip.com.**

Requests for changes to address, phone number, tax I.D., or additions and/or deletions to group practices must be made on the Provider Change Form. It is available in the forms section of the Provider Center on the Keystone First – CHIP Web site at **www.keystonefirstchip.com.**

Providers should utilize the Provider Data Information Form (PDIF) feature in NaviNet.

- This feature allows you to review your provider directory demographic and practice information on file, attest to the accuracy of the information, and make any necessary changes.
- Patient Acceptance Form allows you to verify or change patient acceptance status for individual practitioners at each practice location.
- Demographic changes submitted through the PDIF will be reflected within the online provider directory within 14 business days.

A complete and detailed step-by-step PDIF User Guide on is located on **www.keystonefirstchip.com**.

Providers may also email change forms to **KF_PNM_100@amerihealthcaritas.com**

Provider Services Department

Keystone First – CHIP's Provider Services Department operates in conjunction with the Provider Network Management Department, answering Network Provider concerns and offering assistance. Both departments make every attempt to ensure all Network Providers receive the highest level of service available.

The Provider Services Department can be reached Monday through Friday, 8 AM to 7 PM EST. Assistance is available twenty-four (24) hours a day, seven (7) days a week for emergent provider issues and urgent prior authorization and discharge planning requests.
Call the Provider Services Department at **1-800-521-6007**

- To ask about claims issues
- To ask questions about Provider identification numbers
- To ask questions about notifications
- To verify Enrollee eligibility/benefits
- To request forms or literature
- To ask policy and procedure questions
- To obtain the name of your Provider Account Executive
- To request access to centralized services such as:
    - Outpatient laboratory services
    - Behavioral Health Services
    - Dental Services

- Vision

Enrollee Services

The Enrollee Services Department helps our Enrollees to understand and obtain the benefits available to them. Enrollee Services Representatives are available twenty-four (24) hours a day, seven (7) days a week. Enrollee Services Representatives also provide ongoing support and education to the Keystone First – CHIP Enrollee, focusing on communicating with our Enrollees concerning their utilization of Keystone First – CHIP and managed care principles, policies and procedures. Call the Enrollee Services Department at **1-844-472-2447** to:

- Access on-call nurses after hours
- Assist Enrollees looking for behavioral health information: Call **1-888-700-7030**
- Help educate Enrollees on how to access eligible benefits
- Ask for health education materials in Enrollee's preferred language and formats or request assistance with arranging interpretation services
- Help an Enrollee choose or change a PCP or other Network Provider
- Request a list of Network Providers
- Learn what Enrollees should do if a Health Care Provider sends a bill.

Section V
Primary Care Provider (PCP) & Specialty Provider Office Standards & Requirements

Practitioner & Provider Responsibilities

Responsibilities of All Providers

Providers who participate in Keystone First – CHIP have responsibilities, including but not limited to:

- Be compliant with all applicable Federal and/or state regulations.
- Treat Keystone First – CHIP Enrollees in the same manner as other patients.
- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all applicable disease notification laws in Pennsylvania.
- Provide information to Keystone First – CHIP and/or the Department of Human Services (DHS) as required.
- Inform Enrollees about all available treatment options, regardless of cost or whether such services are covered by Keystone First – CHIP.
- Provide patient medical records/charts as needed when an Enrollee is seeking care from a specialty provider or changing primary care Providers.
- As appropriate, work cooperatively with specialty provider, consultative services and other facilitated care situations for Enrollees with Special Healthcare Needs such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.
- Not refuse an assignment or transfer an Enrollee or otherwise discriminate against an Enrollee solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another Provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the Enrollee's Special Healthcare Needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Provider Agreement (to which this Provider Manual and any revisions or updates are incorporated by reference).
- Accept Keystone First – CHIP payment or third-party resource as payment-in-full for covered services.
- Comply fully with Keystone First – CHIP's Quality Improvement, Utilization Management, Integrated Care Management, Credentialing and Audit Programs.
- Comply with all applicable training requirements as required by Keystone First – CHIP, DHS and/or CMS.
- Promptly notify Keystone First – CHIP of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable

period of time, making such records and other information available to Keystone First – CHIP or any appropriate government entity in accordance with those laws and the Provider Agreement.

- Treat and handle all individually identifiable health information as confidential in accordance with all applicable laws and regulations, including HIPAA Administrative Simplification and Health Information Technology for Economic and Clinical Health (HITECH) requirements.
- Immediately notify Keystone First – CHIP of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify Keystone First – CHIP of the intent to terminate the Provider Agreement as a participating Provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement and DHS requirements.
- Verify Enrollee eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges or a collaborative agreement with a Provider with hospital privileges, when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- **Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.**
- Inform Enrollee(s) of the availability of Keystone First – CHIP's interpretive services and encourage the use of such services, as needed.
- Notify Keystone First – CHIP, in accordance with the terms of the Provider Agreement, of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by State and Federal law.
- Agree that claims data, medical records, practitioner and Provider performance data, and other sources of information, may be used by Keystone First – CHIP to measure and improve the health care delivery services to Enrollees.

PCP Role and Requirements

The PCP is the Enrollee's starting point for access to all health care benefits and services available through Keystone First – CHIP. Although the PCP will certainly treat most of an Enrollee's health care concerns in his or her own practice, Keystone First – CHIP expects that PCPs will refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.

All the instructional materials provided to our Enrollees stress that they should always seek the advice of their PCP before accessing medical care from any other source. It is imperative that the PCP and his or her staff foster this idea and develop a relationship with the Enrollee, which will be conducive to continuity of care.

PCPs are required to contact:

- New Enrollees who have not had an office visit within the first six (6) months of being on the PCP's panel;
- Enrollees who are not in compliance with immunization schedules; and
- Enrollees who have not had an office visit during the previous twelve (12) months (See "Access Standards for PCPs" in this section of the Manual)

Additionally, PCPs are required to:

- Document reasons for non-compliance and the PCP's efforts to bring Enrollee's care into compliance; and
- Identify any Enrollees who have not come into compliance with the immunization schedules within one (1) month of notification by Keystone First – CHIP.

Keystone First – CHIP has the Let Us Know Program to assist practices in Enrollee outreach and contact. See the program description in the Let Us Know section of the manual.

The PCP, or the designated back-up practitioner, should be accessible 24 hours per day, seven days per week, at the office site during all published office hours, and by answering service after hours. When the PCP uses an answering service or answering machine to intake calls after normal hours, the call must be answered within ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

Appointment scheduling should allow time for the unexpected urgent care visit. (See "Access Standards for PCPs" in this section of the Manual)

PCPs should perform routine health assessments as appropriate to a patient's age and sex and maintain a complete individual Enrollee medical record of all services provided to the Enrollee by the PCP, as well as any specialty or referral services.

School-based health services sometimes play a pivotal role in ensuring that children receive the health care they need. PCPs are required, with the assistance of Keystone First – CHIP, to coordinate and/or integrate into the PCP's records any health care services provided by school-based health services. Keystone First – CHIP can help by coordinating services between Parent/Guardian, PCP and other practitioners/Providers. Call our Rapid Response and Outreach team at **1-844-377-2447** for assistance.

PCPs are required to provide examinations for Keystone First – CHIP Enrollees who are under investigation by the County Children and Youth System for suspected child abuse or neglect. Services must be performed in a timely manner.

Providers must be alert for the signs of suspected child abuse, and as mandatory reporters under the Child Protective Services law know their legal responsibility to report such suspicions. To make a report call:

- Childline – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

Additional resources addressing mandatory reporter requirements:

- The Juvenile Law Center of Philadelphia, Child Abuse and the Law : **http://www.jlc.org/resources/publications/child-abuse-and-law**
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**
- Keystone First – CHIP's dedicated web page to child abuse prevention on the Provider center at **www.keystonefirstchip.com**.

In 2010, the Adult Protective Services (APS) Law, **Act 70 of 2010**, was enacted to provide protective services to adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activities. The APS Law establishes a program of protective services in order to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults in need.

A report can be made on behalf of the adult whether they live in their home or in a care facility such as a nursing facility, group home, hospital, etc. Reporters may remain anonymous and have legal protection from retaliation, discrimination, and civil and criminal prosecution. The statewide Protective Services hotline is available 24 hours a day.

Abuse or neglect of Plan Enrollee s age of 18-59 must be reported to Adult Protective Services by calling 1-800-490-8505.

Additional resources may be found here: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Adult-Protective-Services.aspx

PCPs must communicate effectively with Enrollees by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Enrollee. Services must be free of charge to the Enrollee. Refer to the Cultural Responsiveness section of the manual for complete details.

Enrollees have the right to access all information contained in the medical record unless access is restricted for medical reasons.

Completing Medical Forms

In accordance with DHS policy, if a medical examination or office visit is required to complete a form, then you may not charge Keystone First – CHIP Enrollees a fee for completion of the form. Payment for the medical examination or office visit includes payment for completion of forms.

However, you may charge Keystone First – CHIP Enrollees a reasonable fee for completion of forms if a medical examination or office visit is not required to complete the forms. Examples

include forms for driver licenses, camp and/or school applications, working papers, etc. *You must provide Keystone First – CHIP Enrollees with advance written notice that a reasonable fee will be charged for completing forms in such instances. However, if a Keystone First – CHIP Enrollee states that it will be a financial hardship to pay the fee, you must waive the fee.*

The following physical examinations and completion of related forms are not covered by Keystone First – CHIP:

- Federal Aviation Administration (Pilot's License)
- Return to work following work related injury (Worker's Compensation)

PCP Reimbursement

Fee-for-service PCP reimbursement is a payment methodology used by Keystone First – CHIP. If contracted under this methodology, practitioners are required to bill for all services performed in the primary care office. Reimbursement is in accordance with the Fee-for-Service Compensation schedule that is included in the Provider's contract.

Note: All Enrollees are assigned a PCP. As a reminder, it is critical to check Enrollee eligibility prior to the visit (please refer to the Enrollee Eligibility section for the methods available).

Keystone First – CHIP is responsible for reporting utilization data to DHS, on at least a monthly basis. It is therefore necessary that PCP Encounter information be received by Keystone First – CHIP on a regular basis. PCPs are required to submit an Encounter for every visit with an Enrollee whether or not the Encounter contains a billable service. Additional information on Encounter reporting requirements can be found in the later part of this section.

To this end, it is important that all Encounters submitted contain all the diagnoses that have been confirmed by the PCP.

The PCP Office Visit

It is imperative that PCPs verify Enrollee eligibility prior to rendering services to Keystone First – CHIP Enrollees. For complete instructions on looking up eligibility, please refer to the "**Enrollee Eligibility**" Section of the Manual for additional information on verifying eligibility.

As a PCP, it is also necessary to complete and submit a CMS-1500 Form or an EDI Claim (electronic Claim submission) for each Enrollee Encounter (each time an Enrollee receives services, whether the service is capitated or billable above capitation). See "Encounter Reporting" in this section of the Manual for more information concerning Enrollee Encounters.

Access Standards for PCPs

Keystone First – CHIP has established standards to assure accessibility of medical care services. The standards apply to PCPs. PCPs are expected to adhere to the following standards for appointment availability for medical care services, and other additional requirements.

Keystone First – CHIP PCPs are expected to meet the following standards regarding appointment availability and response to Enrollees:

Appointment Accessibility Standards

Appointment Accessibility Standards	
Medical Care:	**Keystone First – CHIP Standard:**
Preventive Care must be scheduled (*health assessment/general physical examinations and first examinations)*	**Within 3 weeks of the Enrollee's Enrollment**
Enrollees for a Bright Futures exam	**With PCP no later than forty-five (45) days after Enrollee enrollment, unless they are already being treated by a PCP or specialist.**
Routine Primary Care must be scheduled	**Within 10 business days of the Enrollee's call**
Urgent Medical Condition Care must be scheduled	**Within 24 hours of the Enrollee's call**
Emergency Medical Condition Care must be seen	**Immediately upon the Enrollee's call or referred to an emergency facility**
After-Hours Accessibility Standards	
Medical Care:	**Keystone First – CHIP Standard:**
After-hours Care by a PCP or a covering PCP must be available *	**24 hours/7 days a week**

* When the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings, and the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

The following are requirements for Enrollees who require specific services and/or have Special Healthcare Needs. Keystone First – CHIP asks that PCPs contact all new panel Enrollees for an initial appointment. Keystone First – CHIP has Care Management Programs that also reach out to Enrollees in the following categories. Keystone First – CHIP expects that PCPs will cooperate in scheduling timely appointments. It is important for the PCP to inform Keystone First – CHIP if he/she learns that an Enrollee is pregnant to assure appropriate follow up. Please call **1-800-521-6867** to refer an Enrollee to the Keystone First – CHIP Bright Start Maternity Program and/or for assistance in locating an OB/GYN practitioner. (OB/GYN services do not require a referral.)

Initial Examination for Enrollees	**Appointment Scheduled with a PCP or Specialist**
with HIV/AIDS	**No later than 7 days of the effective date of Enrollment, unless the Enrollee is already being treated by a PCP or Specialist.**
Enrollees who are pregnant	**Appointment Scheduled with an OB/GYN practitioner**
Pregnant women in their 1st trimester	**Within 10 business days of Keystone First – CHIP learning the Enrollee is pregnant.**
Pregnant women in their 2nd trimester	**Within 5 business days of Keystone First – CHIP learning the Enrollee is pregnant.**
Pregnant women in their 3rd trimester	**Within 4 business days of Keystone First – CHIP learning the Enrollee is pregnant.**
High-risk Pregnant Women	**Within 24 hours of Keystone First – CHIP learning the Enrollee is pregnant or immediately if an Emergency Medical Condition exists.**

Additional Requirements of PCPs

1. The average waiting time for scheduled appointments must be no more than 30 minutes unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour.
2. Patients must be scheduled at the rate of six (6) patients or less per hour.
3. The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record.
4. Number of regular office hours must be greater than or equal to 20 hours per week.
5. Telephonic response time (call back) for non-emergency conditions should be less than two (2) hours.
6. Telephonic response time (call back) for emergency conditions must be less than 30 minutes.
7. Enrollee medical records must be maintained in an area which is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Enrollee medical records, including, obtaining any required written Enrollee consents to disclose confidential medical records.
8. 24 hour/ 7 days per week coverage must be available via the PCP for Urgent and Emergency Medical Condition care. **An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage**. For example, it is not acceptable to have a message on an answering machine that instructs the Enrollee to go to the emergency room for care without providing instructions on how to reach the PCP.
9. When the PCP is notified that the Enrollee has visited the emergency room for either emergency or non-urgent issues, the PCP should contact the Enrollee/Participant within 7-14 days to schedule a follow-up appointment. The PCP may also contact the Let Us Know program staff to request Enrollee intervention and education.
10. PCPs must comply with all Cultural Responsiveness standards. Please refer to "**PCP & specialty provider Office Standards**" in this Section of the Manual, as well as the

"**Regulatory Provisions**" Section of the Manual for additional information on Cultural Responsiveness.

Please refer to "PCP & specialty provider Office Standards" in this section of the Manual for further information on the following practitioner standards:

- Medical Record Standards
- Physical Office Layout

PCP Selection

Enrollees are encouraged to select a Pediatrician/PCP for their newborn prior to receiving services. The Enrollee can enroll their newborn with a PCP by calling Enrollee Services at **1-844-472-2447 (TTY 711)**.

Encounter Reporting

CMS defines an Encounter as "an interaction between an individual and the health care system." Encounters occur whenever a Keystone First – CHIP Enrollee is seen in a practitioner's office, whether the visit is for preventive health care services or for treatment due to illness or injury. An Encounter is any health care service provided to a Keystone First – CHIP Enrollee. Encounters, whether reimbursed through capitation, fee-for-service, or another method of compensation, must result in the creation and submission of an Encounter record (CMS-1500 form or electronic submission) to Keystone First – CHIP. The information provided on these records represents the Encounter data provided by Keystone First – CHIP to DHS.

Completion of Encounter Data

PCPs must complete and submit a CMS-1500 form or file an electronic Claim every time a Keystone First – CHIP Enrollee receives services. Completion of the CMS-1500 form or electronic Claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services covered beyond capitation, including payment of inpatient newborn care and attendance at high-risk deliveries
- It allows Keystone First – CHIP to gather statistical information regarding the medical services provided to Keystone First – CHIP's Enrollees, which better support our statutory reporting requirements
- It allows Keystone First – CHIP to identify the severity of illnesses of our Enrollees
- It allows Keystone First – CHIP to report HEDIS/Quality data to DHS.

Keystone First – CHIP can accept Encounter Claim submissions via paper or electronically (EDI). For more information on electronic Claim submission and how to become an electronic biller, please refer to the "EDI Technical Support Hotline" topic in Section IV of the Manual or the Claims Filing Instructions in Section VI.

In order to support timely statutory reporting requirements, we encourage Providers to submit Encounter information within 30 days of the Encounter. However, all Encounters (Claims) must be submitted within 180 calendar days after the services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- Keystone First – CHIP Enrollee's ID number
- Enrollee's name
- Enrollee's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOBs
- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM diagnosis codes, coded to the highest level of specificity.
- Authorization number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT I and/or CPT II, procedure codes with appropriate modifiers
- Charges
- Days or units/NDC when applicable
- Physician/supplier federal tax identification number or Social Security Number
- National Practitioner ID (NPI) and Taxonomy Code
- Individual Keystone First – CHIP assigned practitioner number
- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Please see "Claims Filing Instructions" in Section VI of the Manual for additional information for the completion of the CMS form.

Keystone First – CHIP monitors Encounter data submissions for accuracy, timeliness and completeness through Claims processing edits and through Network Provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network Providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to Keystone First – CHIP. Network Providers may be subject to sanctioning by Keystone First – CHIP for failure to submit 100% of Encounters. Network Providers may also be subject to sanctioning by Keystone First – CHIP for failure to submit accurate Encounter data in a timely manner.

Transfer of Non-Compliant Enrollees

By PCP request, any Enrollee whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel. Keystone First – CHIP's goal is to accomplish the uninterrupted transfer of care for an Enrollee who cannot maintain an effective relationship with his/her PCP.

A written request on your letterhead asking for the removal of the Enrollee from your panel must be sent to the Provider Services Department that includes the following:

- The Enrollee's full name and Keystone First – CHIP identification number
- The reason(s) for the requested transfer
- The requesting PCP's signature and Keystone First – CHIP identification number

Transfers will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed emergency care.

The Provider Services Department will assign the Enrollee to a new PCP and will notify both the Enrollee and requesting PCP when the transfer is effective.

Requesting a Freeze or Limitation of Your Enrollee Panel

Keystone First – CHIP recognizes that a PCP will occasionally need to limit the volume of patients in his/her practice in the interest of delivering quality care. **Keystone First – CHIP must have 90 days advance written notice of any request to change panel status.** For example, a panel limitation or freeze request received on May 1 would become effective on August 1. When requesting to have Enrollees added to panels where age restriction or panel limitations exist, Keystone First – CHIP must be notified in writing on the PCP office's letterhead.

Policy Regarding PCP to Enrollee Ratio

PCP sites may have up to 1,000 CHIP Enrollees per each full-time equivalent PCP at the site.

Letter of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, PCPs may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a Network Provider or facility
- Initial documentation submitted is insufficient for Keystone First – CHIP to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Keystone First – CHIP's Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff person managing the case of the Enrollee in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Enrollee's name and Keystone First – CHIP identification number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Enrollee

- Other treatment or testing methods, which have been tried but have not been successful along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure that is being requested

PCP Responsibilities Under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both the "living will" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

PCPs should be aware of, and discuss, the Patient Self-Determination Act with their adult patients. Specific responsibilities of the PCP are:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not she/he has executed an advance directive
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives

Keystone First – CHIP provides our Enrollees with information about the Patient Self-Determination Act via the Enrollee Handbook. Excerpts from the Enrollee Handbook regarding this topic can be found in Section X of the Manual entitled "Enrollee Rights and Responsibilities."

Preventive Health Guidelines

The Preventive Health Guidelines were adopted from the U.S. Preventive Services Task Force. The contents of these guidelines were carefully reviewed and approved by peer Providers at Keystone First – CHIP's Clinical Quality Improvement Committee. As with all guidelines, the Keystone First – CHIP Preventive Health Guidelines are based on recommendations from the U.S. Preventive Services Task Force and are not intended to interfere with a Health Care Provider's professional judgment.

Clinical Practice Guidelines

Keystone First – CHIP has adopted clinical practice guidelines for use in guiding the treatment of Keystone First – CHIP Enrollees, with the goal of reducing unnecessary variations in care. The Keystone First – CHIP clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

Keystone First – CHIP's Clinical Practice Guidelines are available in the Provider Center at **www.keystonefirstchip.com → Providers → Resources→ Clinical Practice Guidelines.** or call your Provider Account Executive to request a copy.

In support of the above guidelines, Keystone First – CHIP has Disease Management and Care Management programs available to assist you in the education and management of your patient with chronic diseases. For information, a copy of the above clinical guidelines, or to refer a Keystone First – CHIP Enrollee for Disease or Care Management Services, call the Enhanced Member Supports Unit (EMSU) at 1-844-377-2447**.**

Specialty Care Providers

The Specialty Provider Office Visit

Keystone First – CHIP Enrollees receive specialty provider services from Network Providers via a referral from their PCP's office. Specialty provider services are reimbursed on a fee-for-service basis at the Provider's contracted rate.

Prior to rendering services, specialty providers should always verify Enrollee eligibility, which can be done by checking "Enrollee Eligibility" through NaviNet online at **www.navinet.net** or by calling Provider Services at **1-800-521-6007**. For more information, please refer to "Referral & Authorization Requirements" in Section II of this Manual. Specialty providers should provide timely communication back to the Enrollee's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care. It is necessary for all Network Providers to adhere to the applicable office standards as outlined in "PCP & specialty provider Office Standards" in this Section.

Reimbursement/Fee-for-Service Payment

Keystone First – CHIP will reimburse all contracted specialty providers at fee-for-service rates described in the Network Provider's individual Keystone First – CHIP Specialty Care Provider Agreement.

Please refer to "Claims Filing Instructions" in Section VI of the Manual for complete billing instructions. Should you determine the need for diagnostic testing or procedures requiring authorization, please contact Keystone First – CHIP's Utilization Management Department via phone, fax, or provider portal to obtain authorization.

Specialty Provider Services

Specialty providers shall provide Medically Necessary covered services to Keystone First – CHIP Enrollees. These services include:

- Ambulatory care visits and office procedures
- Arrange or provide inpatient medical care at a Keystone First – CHIP participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week

All Providers, particularly emergency, critical care and urgent care Providers must be alert for the signs of suspected child abuse, and as mandatory reporters under the Child Protective Services law, know their legal responsibility to report such suspicions. To make a report call:

- Childline – **1-800-932-0313**, a 24-hour toll free telephone reporting system operated by the Pennsylvania Department of Human Services to receive reports of suspected child abuse.

Additional resources addressing mandatory reporter requirements:

- **The Juvenile Law Center of Philadelphia, Child Abuse and the Law : http://www.jlc.org/resources/publications/child-abuse-and-law**
- The Center for Children's Justice, Child Protection FAQ's: Reporting Child Abuse in Pennsylvania: **http://www.c4cj.org/Child_Abuse_in_PA.php**
- Keystone First – CHIP's dedicated web page to child abuse prevention at **www.keystonefirstchip.com**

Specialty Provider Access & Appointment Standards

The average office waiting time should be no more than 30 minutes, or no more than one (1) hour when the Network Provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. Scheduling procedures should ensure:

- Emergency appointments immediately upon referral
- Urgent Care appointments within twenty-four (24) hours of referral
- Routine appointments within ten business days of the referral
- Routine appointments within 15 business days of the referral for the following specialties: Otolaryngology, Dermatology, Dentist, Orthopedic Surgery, and the following Pediatric specialties: Endocrinology, General Surgery, Infectious Disease, Neurology, Pulmonology, Rheumatology, Allergy & Immunology, Gastroenterology, Hematology, Nephrology, Oncology, Rehab and Urology.

Network Providers must have a "no-show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record.

Confidentiality of Medical Records

Patient medical records must be maintained in an area that is not accessible to those not employed by the practice. Network Providers must comply with all applicable laws and regulations pertaining to the confidentiality of Enrollee medical records, including obtaining any required written Enrollee consents to disclose confidential medical records. Please refer to "Medical Record Standards" in this section of the Manual for further information on the maintenance of medical records.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, Health Care Providers may be requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a Network Provider or facility
- Initial documentation submitted is insufficient for Keystone First – CHIP to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The Enrollee's name and Keystone First – CHIP ID number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the Enrollee
- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested

Specialty Provider Responsibilities Under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Since 1992, Pennsylvania law has allowed both "living wills" and "durable power of attorney" as methods for patients to relay advance directives regarding decisions about their care and treatment.

Specialty providers should be aware of and discuss the Patient Self-Determination Act with their adult patients. Specific responsibilities of the specialty provider are outlined below:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient’s medical record, and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not he/she has executed an advance directive
- Ensure compliance with the requirements of Pennsylvania state law concerning advance directives

Keystone First – CHIP provides our Enrollees with information about the Patient Self-Determination Act via the Enrollee Handbook. Excerpts from the Enrollee Handbook regarding this topic can be found in “Enrollee Rights and Responsibilities” in Section X of the Manual.

Specialty Provider as a PCP for Enrollees with Special Healthcare Needs

Refer to the Special Healthcare Needs and Care Management Section for complete details. Providers who are willing to serve/care for Enrollees with Special Healthcare Needs should contact their Provider Account Executive.

PCP & OB/GYN Office Standards

Physical Environment

Keystone First – CHIP conducts an initial office site visit to all potential PCP and OB/GYN sites. Provider Network Management considers the results of the office site visit in making a determination as to whether the Health Care Provider will be approved for participation in Keystone First – CHIP's Network. The office site visit is intended to collect information about Provider performance in the following areas:

- Facility Information
- Safety
- Provider Accessibility
- Treatment Areas
- General Information

The following are examples of standards that must be met for Keystone First – CHIP network participation:

1. Office must have visible signage and must be handicapped-accessible*
2. Office hours must be posted
3. Office must be clean and presentable
4. Office must have a waiting room with chairs
5. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
6. Office must have at least two examination rooms that allow for patient privacy
7. Office must have the following equipment:
   a) Examination table
   b) Otoscope
   c) Ophthalmoscope
   d) Sphygmomanometer
   e) Thermometers
   f) Needle disposal system
   g) Accessible sink/hand washing facilities
   h) Bio-hazard disposal system
8. There must be a system in place to properly clean/decontaminate and sterilize reusable equipment. Bio-medical equipment must be part of an annual preventive maintenance program
9. Office must have properly equipped (handicapped-accessible) restroom facilities, readily accessible to patients

10. There are safeguards to maintain confidentiality/security of medical records and patient identifiable information (as they relate to visual and computer access, office conversations, only authorized personnel have access to record).
11. Must have written procedures for medical emergencies and a written evacuation plan. During patient hours, at least one staff person must be CPR-certified
12. The office must be equipped with at least one fire extinguisher that is properly serviced and maintained
13. Must have blood-borne pathogen exposure control plan
14. Medications must be stored in a secure place away from public areas. Refrigerators used for medication storage must have a thermometer. Controlled substances must be locked, and prescription pads must be kept in a secure place

* Title III of the Americans with Disabilities Act (ADA, 42 U.S.C. 12101 et seq.) states that places of public accommodation must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as Health Care Providers) must specifically comply with, among other things, requirements related to effective physical accessibility, communication with people with hearing, vision, or speech disabilities, and other access requirements. For more information, you can go to the Department of Justice's ADA Home Page **https://www.ada.gov/index.html**.

Medical Record Standards

Complete and consistent documentation in patient medical records is an essential component of quality patient care. Keystone First – CHIP adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Compliance with the Plan's medical record standards and preventive health guidelines are evaluated, not less than every 2 years, based on a random selection process and/or as determined by the Plan for Primary Care Providers (PCP), Obstetrics and Gynecology (OB/GYN) Providers, high impact/high-volume specialty providers, and other Providers as deemed appropriate. Providers are notified of Plan medical standards through the Provider newsletter and website. PCPs and specialty providers also receive a copy of the standards at the time of their initial and subsequent site visit.

Keystone First – CHIP performs an annual medical record review on a random selection of practitioners. The medical records are audited using these standards.

The following is a list of our standards:

- Medical records are organized in a consistent manner for easy retrieval, and the records are kept secure, confidential, and only authorized staff have access
- Staff receive training in Participant information confidentiality
- Patient's name or identification number is included on each page of record
- All entries are legible, initialed, or signed and dated by the author
- Personal and biographical data are included in the record
- All services are provided by a PCP or allied health professional under the supervision of a PCP. Current and past medical history and age-appropriate physical exams are documented including serious accidents, operations, and illnesses

- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA"
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening
- An updated problem list is maintained.
- Patient's chief complaint or purpose for visit is clearly documented
- Clinical assessment and/or physical findings are recorded. Appropriate working diagnoses or medical impressions are recorded for each visit
- Plans of action/treatment are consistent with diagnosis
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure
- Unresolved problems from previous visits are addressed in subsequent visits
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the Network Provider and updated as needed
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate
- Screening and preventive care practices are in accordance with the Keystone First – CHIP Preventive Health Guidelines
- An immunization record is up to date
- Requests for consultations are consistent with clinical assessment/physical findings
- Laboratory and other studies are ordered, as appropriate
- Laboratory and diagnostic reports reflect Network Provider review
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented
- There is evidence of continuity and coordination of care between PCPs and specialty providers
- Providers are required to achieve a medical record score of 90% or greater to meet the Plan's standards.
- Providers that do not achieve the score of 90% will have re-audit within 120 days to ensure that the deficiencies area corrected.
- Results for Providers not achieving a passing score of 90% on the re-audit are presented to the Plan’s Credentialing Committee for review and recommendations. The Provider will be notified of the Committee's recommendations within ten (10) business days. The Plan’s Quality Management Department will provide oversight of Committee's recommendations, and any Correction Action Plan’s requested for specific Provider practices.

Medical Record Retention Responsibilities

Medical records must be preserved and maintained for a minimum of ten (10) years from termination of the Health Care Provider’s agreement with Keystone First – CHIP or as otherwise required by law or regulatory requirement. Medical records may be maintained in paper or electronic form; electronic medical records must be made available in paper form upon request.

Section VI
Claims

Keystone First – CHIP Claims Filing Instructions

The Keystone First – CHIP Claims Filing Instructions can be found in the Appendix of the Manual or accessed online in the Provider Center at www.keystonefirstchip.com.

National Provider Identification Number

The National Provider Identifier (NPI) is a Federally issued 10-digit unique standard identification number that all Health Care Providers must use when submitting electronic claims.

Electronic claims submitted without an NPI will be rejected back to the Provider via their EDI clearinghouse. Network Providers who submit claims via paper CMS 1500 or UB-04 are also required to include their NPI on their claims.

Keystone First – CHIP strongly encourages Network Providers to continue to submit claims with their Keystone First – CHIP Provider ID, in addition to the required NPI number.

How to Apply for Your NPI

Health Care Providers may apply for their NPI in one of the following ways:

- Complete the web-based application at **https://nppes.cms.hhs.gov**. This process takes approximately 20 minutes to complete
- Call the Enumerator call center at **1-800-465-3203** or TTY **1-800-692-2326** to request a paper application
- E-mail **customerservice@npienumerator.com** to request a paper application
- Request a paper application by mail:

NPI Enumerator
7125 Ambassador Road
Suite 100
Windsor Mill, MD 21244

NOTE: The most time-efficient method of getting an NPI is the web-based application process.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), Providers participating with Keystone First – CHIP must participate in the Pennsylvania Medical Assistance Program.

All Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

This means Providers must enroll and meet applicable Medical Assistance Provider requirements of DHS and receive a Pennsylvania Promise ID (PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

DHS has expressed its intent to terminate Medical Assistance enrollment of all non-compliant Providers. Keystone First – CHIP will comply with DHS's expectation that non-compliant Providers will also be terminated from our network, since medical assistance enrollment is a requirement for participation with Keystone First – CHIP.

Important note: This does not apply to non-participating out-of-state Providers under single case agreements.

DHS may make a determination that adopts encounter limits or thresholds that would require the non-participating out-of-state Providers to convert to in-network status, which would require enrollment in the Pennsylvania Medical Assistance Program.

Enroll by visiting: **https://www.pa.gov/services/dhs/enroll-as-a-medicaid-provider.html**

The Department of Human Services (DHS) also requires that Providers obtain an NPI and share it with them. Further information on DHS's requirements can be found at **https://www.dhs.pa.gov/providers/Providers/Pages/NPI.aspx**.

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Prospective Claims Editing Policy

Keystone First – CHIP's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to legislative or

regulatory mandates, a Provider's contract, and/or an Enrollee's eligibility to receive covered health care services.

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to Keystone First – CHIP within 180 calendar days from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of **rejected Claims must occur within 180 calendar days** from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at **www.keystonefirstchip.com**.

Please note – If a claim is paid and it is later discovered there was other insurance, Keystone First – CHIP will recover all reimbursement paid to the Provider.

Failure to Comply with Claim Filing Deadlines

Keystone First – CHIP will not grant exceptions to the Claim filing timeframes outlined in this section. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of Keystone First – CHIP's right to deny any future Claims that are filed after the deadlines or as a waiver of Keystone First – CHIP's right to retract payments for any Claims paid in error.

Third-Party Liability and Coordination of Benefits

1. Children enrolled in free and low-cost CHIP will no longer lose CHIP coverage because families obtain private health insurance or fail to pay monthly premiums.
2. If there is no private health insurance at the time of application or renewal and the enrollee meets all eligibility criteria, they will be enrolled after the first premium payment is made.
3. Full Cost CHIP coverage will stop if minimum payments are not made during the 12-month eligibility period or if private health insurance is obtained.

Coordination of Benefits (COB) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as Keystone First – CHIP, are always the **payer of last resort.** This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to Keystone First – CHIP. Therefore, before billing Keystone First – CHIP when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone First – CHIP for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Commercial Third-Party Resources

For services that have been rendered by a Network Provider, Keystone First – CHIP will pay, up to the Keystone First – CHIP contracted rate, the lesser of:

- The difference between the Keystone First – CHIP contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and Keystone First – CHIP will not exceed Keystone First – CHIP's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone First – CHIP will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health Care Providers must comply with all applicable Keystone First – CHIP referral and authorization requirements.

Program Integrity

The Program Integrity Department is responsible for identifying and recovering claims overpayments for the Medicaid population which Keystone First – CHIP serves. The department performs several operational activities to ensure the accuracy of claim payments.

As a Provider participating in Keystone First – CHIP's network, you are responsible to know and abide by all applicable state and federal laws and regulations and by the fraud, waste, and abuse requirements of Keystone First – CHIP's contract with the Pennsylvania Department of Human Services. Violations of these laws and regulations may be considered fraud, waste or abuse against the Medical Assistance program. Some of the federal fraud and abuse laws physicians must be familiar with include the False Claims Act (31 U.S.C. §§3729-3733) ("FCA"), the Anti-Kickback Statute (42 U.S.C. §1320a-7b(b)), the Physician Self-Referral Law, also known as the Stark law (42 U.S.C. §1395nn), and the federal Exclusion Statute (42 U.S.C. §1320a-7).

The Plan is obligated to ensure the effective use and management of public resources in the delivery of services to its Enrollees. The Plan does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and to the detection and prevention of fraud, waste, and abuse. In connection with these programs, you

may receive written or electronic communications from or on behalf of the Plan, regarding payments or the recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your Provider contract, and with state and federal law. Examples of these Program Integrity initiatives include:

- Prospective (Pre-claims payment)
    - Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or the Plan medical/claim payment policy) are applied to prepaid claims.
    - Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
        - Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
    - Coordination of Benefits ("COB") - Process to verify third party liability to ensure that the Plan is only paying claims for Enrollees where the Plan is responsible, i.e. where there is no other health insurance coverage.
    - Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.
- Retrospective (Post-claims payment)
    - Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, The Plan is by federal statute the payer of last resort. The effect of this rule is that the Plan may recover its payments if it is determined that an Enrollee had other health insurance coverage at the time of the service.
    - Please also see Section 6 Claims for further description of TPL/COB/Subrogation.
    - Data Mining – Using paid claims data, the Plan identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
    - Medical Record /Itemized Bill Review – a Medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. The scope of the validation may encompass any or all of the procedures, diagnosis or diagnosis-related group ("DRG") billed by the Provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.
        - *Please note if medical records are not received within the requested timeframe, the Plan will recoup funds from the Provider. Your failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the records.*
- Credit Balance Issues
    - Credit balance review service may be conducted in-house at the Provider's facility to assist with the identification and resolution of credit balances at the request of the Provider.

- Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you may be requested to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. The Plan reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the Enrollee's eligibility changes between the time authorization was issued and the time the service was provided.

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from Providers causing overpayment
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility

The Claims Cost Containment Unit is also responsible for the manual review of Provider-initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

Keystone First – CHIP
Attention: Claims Recovery
P.O. Box 211361
Eagan, MN 55121

Refunds for Claims Overpayments or Errors

Keystone First – CHIP and DHS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to adhere to the following requirements: In accordance with 42 U.S.C. §1320a-7k(d), in most cases, overpayments must be reported and returned to Keystone

First – CHIP within sixty (60) days of identification. Section 6402(a) of the Affordable Care Act establishes that an overpayment retained beyond the timeframe established in 42 U.S.C. §1320a-7k(d) is an obligation per the federal False Claims Act ("FCA"). Providers who improperly retain an overpayment may be subject to liability, including penalties and damages, under the FCA.

1. Contact Keystone First – CHIP Provider Claim Services at 1-800-521-6007 to arrange the repayment. There are two ways to return overpayments to Keystone First – CHIP:
   - Have Keystone First – CHIP deduct the overpayment/improper payment amount from future claims payments, or
   - Return the overpayments directly to Keystone First – CHIP:
     - Use the Provider Claim Refund form when submitting return payments to Keystone First – CHIP. A sample form is available on the Provider Center at **www.keystonefirstchip.com** under Forms.
     - Mail the completed form and refund check for the overpayment/improper payment amount to:

       Keystone First – CHIP
       Attention: Provider Refunds
       P.O. Box 21152
       Eagan, MN 55121

Note: Please include the Enrollee's name and ID, date of service, and Claim ID

2. Providers may follow the "*Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol"* to return improper payments or overpayments. Access the DHS voluntary protocol process via the following web address:

   https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

Special Investigations Unit

Keystone First – CHIP has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Our existing program has been developed in accordance with 42 CFR § 438.608, 42 CFR Part 455, the governing contracts between Keystone First – CHIP and the Commonwealth of Pennsylvania, and applicable federal and state laws. The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with the requirements as set forth in 42 C.F.R. Part 438, Subpart H (Certifications and Program Integrity) and 42 C.F.R. § 457.950(a)(2) as well as Federal Regulations 42 CFR §457.1285 referencing §438.608 (a) (7-8) and 42 CFR§457.935 referencing §455.23(a).

The Special Investigations Unit (SIU) is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claims payment processes for Keystone First – CHIP. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste and abuse.
- Takes corrective actions for any supported allegations after thorough investigation, including recovering overpayments that result from fraud, waste, or abuse.
- Reports confirmed misconduct to the appropriate parties and/or agencies.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the CHIP-MCO, a subcontractor, a Provider, or an Enrollee, among others.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to CHIP, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFA, Agreement, and the requirements of state law or federal regulations) for health care in a managed care setting. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider or entity has not knowingly or intentionally misrepresented facts to obtain payment. The Abuse can be committed by the CHIP-MCO, Subcontractor, Provider, State employee, or an Enrollee, among others. Abuse also includes Enrollee practices that result in unnecessary cost to CHIP, the CHIP-MCO, a Subcontractor, or Provider.

The mandatory Fraud, Waste, and Abuse Provider Training presentation can be found on our website at **www.keystonefirstchip.com**. After you have completed the training, please complete the attestation using the link on our website.

Recipient Fraud: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits and for example, that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering

prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

Provider Fraud: For example, billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect Provider or service location); altering claims, submission of any false data on claims, such as date of service, Provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

Fraud, Waste & Abuse – Summary of Relevant Laws and Examples

Keystone First – CHIP receives state and federal funding for payment of services provided to our Enrollees. In accepting Claims payment from Keystone First – CHIP, Health Care Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to **www.pacode.com/secure/data/055/partIIItoc.html** for more information regarding Fraud or abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

Keystone First – CHIP is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Section of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services. As part of Keystone First – CHIP's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and/or abusive activities.

Bureau of Program Integrity Retrospective Review

The Department of Human Services, Bureau of Program Integrity (Department), is responsible for the retrospective monitoring and review of services for compliance with Medical Assistance (MA) regulations. As part of this monitoring process, a CHIP Managed Care Organization's (CHIP-MCO) in and out of network Provider's paid claims and the Department's encounters are validated, and pertinent medical and/or financial records are reviewed to ensure payment was properly made by the MCO. See 55 Pa. Code §§ 1101.51(e) and 1101.71(a).

Rebuttals

Any Provider rebuttals in relation to the Bureau of Program Integrity's (BPI) initiated Retrospective Review Process, are to be filed within the timeframes outlined within BPI's preliminary and final finding letters.

Provider Corrective Action Plan (PCAP)

As a result of the retrospective reviews that has been initiated by the Department of Human Services, Bureau of Program Integrity Division; Keystone First – CHIP must submit a Provider Corrective Action Plan to the Department to resolve any Network Provider's regulatory violations as cited in the final findings notice from BPI.

At the conclusion of the retrospective review of a Provider in which area(s) of noncompliance have been identified, the Department will issue a final findings letter that may require the submission of a PCAP to the Department.

Upon receiving confirmation from the Department of the required PCAP, Keystone First – CHIP's Provider Network Management team will work with the Provider to develop a corrective action plan that addresses the area(s) of noncompliance, and all applicable federal and state regulations identified in the Department's final findings letter. The Provider corrective action plan will reiterate program deficiencies, specify an efficient path toward overall improvement, monitor imposed changes (making adjustments as necessary) and advance accurate and expedient program delivery.

Keystone First – CHIP will send the PCAP to the Department for approval within sixty (60) calendar days of the Plan's receipt of the final findings letter.

- If approval is received from the Department the PCAP will be tracked and monitored for compliance for a period of at least (90) calendar days.
- If a denial is received from the Department with an indication of revision to the PCAP, the Keystone First – CHIP Provider Network Management team will work with the Provider to address all the Department's concerns. The revised PCAP will be submitted to the Department upon receipt.
- Once the Keystone First – CHIP Provider Network Management team has validated that all action items within the PCAP have been completed, the PCAP will be closed.

The Federal False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Penalties for violating the FCA include damages in the amount of up to three times the amount of the false claim plus civil penalties of $14,308 - $28,619 per false claim.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

The Federal Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA.

Among other things, FERA:

- Expands potential liability under the FCA for government contractors like Keystone First – CHIP.
- Expands the definition of a false or fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like Keystone First – CHIP.
- Expands the definition of a false record to include any record that is material to a false or fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Pennsylvania has not yet enacted a false claims statute similar to the federal FCA. Pennsylvania does, however, have anti-fraud laws that impose criminal and civil penalties for false claims and false statements.

The Pennsylvania Fraud and Abuse Controls, 62 P.S. §§ 1407, 1408

This law, 62 P.S. § 1407, applies to Medicaid Providers and prohibits the submission of false or fraudulent claims to Pennsylvania's Medical Assistance programs as well as the payment of kickbacks in connection with services paid in whole or in part by a Medical Assistance program. A violation of the law is a criminal felony offense that carries with it penalties of imprisonment of up to 7 years, fines, and mandatory exclusion from Pennsylvania's Medical Assistance programs for 5 years. In addition to criminal penalties, the law authorizes the Pennsylvania Department of Human Services to institute a civil action against a Provider and seek as damages two times the amount of excess benefits or payments paid plus interest.

Pennsylvania has another anti-fraud law, 62 P.S. § 1408, that prohibits anyone from making false claims or false statements in connection with an application for Medical Assistance benefits or payments. Depending upon the nature of the violation, criminal penalties range from felony to misdemeanor offenses. In addition, the Pennsylvania Department of Human Services may institute a civil action against a person who violates this section and seek as damages the amount of the benefits obtained. The Pennsylvania Department of Human Services may also impose a penalty in the amount of $1,000 against any such person for each violation of the law.

The Pennsylvania Whistleblower Law, 43 P.S. §§ 1421 to 1428

The Pennsylvania Whistleblower Law provides protection from discrimination and retaliation to a person who witnesses or has evidence of wrongdoing or waste while employed and who makes a good faith report of the wrongdoing or waste, verbally or in writing, to one of the person's superiors, to an agent of the employer, or to an appropriate authority.

No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writing, to the employer or appropriate authority an instance of wrongdoing or waste by a public body or an instance of waste by any other employer as defined in the act. In addition, no employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee is requested by an appropriate authority to participate in an investigation, hearing or inquiry held by an appropriate authority or in a court action. A person who, under color of an employer's authority, violates this act shall be liable for a civil fine of not more than $10,000.

In addition, a whistleblower that is retaliated against may bring an action in court and seek the following relief: reinstatement, the payment of back wages, full reinstatement of fringe benefits and seniority rights, actual damages, or any combination of these remedies. A court shall also award the whistleblower all or a portion of the costs of litigation, including reasonable attorney's fees, if the whistleblower prevails in the civil action.

Examples of fraudulent/abusive/wasteful activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Enrollees
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for Provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare, Medicaid and CHIP programs
- Retaining Medicaid funds that were improperly paid
- Billing Enrollees for covered services
- Failure to perform services required under a capitated contractual arrangement
- Misrepresentation of dates and times of service
- Misuse of Electronic Medical Records such as cloning and copying so records are identical, not unique and specific as required.
- Failing to have supporting documentation for billed services
- Submitting multiple claims for the same services

Reporting and Preventing Fraud, Waste and Abuse (FWA)

If you, or any entity with which you contract to provide health care services on behalf of Keystone First – CHIP beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact Keystone First – CHIP by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**;
- E-mailing to **FraudTip@amerihealthcaritas.com**;
- Mailing a written statement to Special Investigations Unit, Keystone First – CHIP, 3875 West Chester Pike, Newtown Square, PA 19073

Below are examples of information that will assist Keystone First – CHIP with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse directly to the Pennsylvania Department of Human Services through one of the following methods:

Phone: 1-866-347-8477
Online: www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx
Fax: 1-717-772-4655, Attn: MA Provider Compliance Hotline
Mail:
Department of Human Services
Office of Administration
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675

What to Expect as a Result of SIU Activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments, and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Keystone First – CHIP, or on behalf of Keystone First – CHIP, regarding recovery of potential overpayments and/or requesting medical

records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns

- You may also be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by an investigator in regards to a complaint they are investigating which may or may not concern you.
- As a Provider you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records. Keep in mind that per your Provider agreement, you are required to provide the records for review.

> *Provider agrees to cooperate with Keystone First – CHIP in maintaining and providing to Keystone First – CHIP or the Department, at no cost to them, medical records, financial data, administrative materials and other records related to services to Enrollees as may be reasonably requested by Keystone First – CHIP and/or the Department.*

After an investigation is completed, there are a number of things that may occur such as a determination that the complaint was unfounded or a referral to: (1) the Bureau of Program Integrity for the Pennsylvania Department of Human Services, (2) the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section or (3) the federal Office of Inspector General for further investigation. You may receive an overpayment letter that outlines what was found and if monies are owed. You could also receive and education letter that outlines proper procedures that are to be followed for future reference. You could be placed on prepayment review.

What is an SIU Dispute?

Providers are permitted to file an SIU Dispute, which is a written response with supporting documentation in disagreement with all or part of the SIU findings in an Overpayment Letter from the SIU. The specific number of disputes and related processes are designated by the noted regulations of the line of business and adhered to by the SIU. This process is restricted to the SIU and there are no other internal dispute processes available to providers in response to an identified overpayment.

Filing a Request for a First Level SIU Dispute Review

Instructions for filing a request for a First Level SIU Dispute review are included in the SIU Overpayment Letter, pertaining to the established guidelines and time frames of the Plan Agreement.

- Please note, the SIU process pertains to the SIU actions involving overpayments identified.
- Providers have 30 calendar days from the receipt of the SIU Overpayment Letter to file a First Level Dispute of the SIU findings.
- First Level Disputes are to be submitted in writing, within 30 days of the receipt of the SIU Overpayment letter. The letter is to include the following:

  - Copy of the SIU Overpayment Letter received with the Case Number.
  - The provider reason for the First Level SIU Dispute.
  - Appropriate supporting documentation for the dispute of the SIU findings (examples, time sheets, physician information and recommendations, etc. This is not an exhaustive list of documents to be included).
- First Level Disputes of SIU determinations are to be sent to:
  Keystone First CHIP
  Attention: Assigned SIU Investigator (contact information in the Overpayment Letter received) and (SIU Case Number in the Overpayment Letter)
  P.O. Box 80112
  London, KY 40742

Time Frame for Resolution of a First Level SIU Dispute

Providers will receive a First Level SIU Dispute Response Letter and corresponding audit spreadsheet of claims following the completion of the SIU review.

Filing a Request for a Second Level SIU Dispute Review

Instructions for submitting a request for a Second Level SIU Dispute review are included in the First Level SIU Dispute Response Letter, pertaining to the established guidelines and time frames of the Plan Agreement.

- Please note, the SIU process relates to the SIU actions involving overpayments identified.
- Providers have 30 calendar days from the receipt of the First Level SIU Dispute Response Letter to file a Second Level Dispute.
- Second Level SIU Disputes are to be submitted in writing, within 30 days of receipt of the SIU overpayment letter. The letter should include the following:
  - Copy of the First Level SIU Dispute Response Letter received with the Case Number.
  - The reason for the Second Level SIU Dispute.
  - Appropriate supporting documentation for the dispute of SIU findings. (examples, time sheets, physician information and recommendations, etc. This is not an exhaustive list of documents to be included.)
- Second Level Disputes of SIU determinations are to be sent to:
  Keystone First CHIP
  Attention: Assigned SIU Investigator (contact information in the Overpayment Letter received) and (SIU Case Number in the Overpayment Letter)
  P.O. Box 80112
  London, KY 40742

Time Frame for Resolution of a Second Level SIU Dispute

Providers will receive a Second Level SIU Dispute Response Letter and corresponding audit spreadsheet with the determinations of the review.

Resolution of the SIU Dispute Process

The SIU Dispute process ends with the Second Level SIU Dispute Response Letter to the provider. The SIU Dispute process is considered to be exhausted after the Second Level SIU Dispute Response and any applicable identified overpayment(s) must be returned to Keystone First - CHIP. The SIU dispute process is the exclusive, internal remedy that is available for providers to respond to an identified SIU overpayment. All other dispute or appeals processes (i.e. Informal Provider Disputes or Formal Provider Appeals) referenced within this provider manual are not applicable. The SIU Dispute process is different and separate from all other dispute or appeal processes permitted to the provider network.

Claim Dispute and Appeals

Keystone First – CHIP's goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Rejected Claims are returned to the Health Care Provider or EDI source without registration in the Claim processing system. Since rejected Claims are not registered in the Claim processing system, the Health Care Provider must re-submit corrected Claims within 180 calendar days from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - within 180 days of date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information for payment under Plan guidelines is missing must be resubmitted for correction. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health Care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate "Corrected Claims" on the Claim form:

Corrected Claims/Adjusted Claims
Keystone First – CHIP
P.O. Box 21152

Eagan, MN 55121

Resubmitted EDI Corrected Claims

Providers using electronic data interchange (EDI) can submit "professional" corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at **1-877-234-4271** or: **edi@keystonefirstpa.com**
    - Providers using our NaviNet portal, (**www.navinet.net**) can view their corrected claims faster than available with paper submission processing.

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code). Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. **If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can call Keystone First – CHIP's Provider Claim Services Unit (PCSU) at 1-800-521-6007 to report payment discrepancies**. Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Emergency Room Payment Limitations

No payment will be made for Emergency Room services if:

- The Enrollee is not eligible for benefits on the date of service
- The Enrollee is admitted, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU,

Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section II for notification requirements

- The service was provided outside of the United States or its territories.

If your Claim issues are not resolved following the steps outlined above, the procedures outlined in Section VII may be followed. If the Network Provider disagrees with Keystone First – CHIP's Dispute decision, the Network Provider may file a Formal Provider Appeal.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365-day timeframe is exceeded.

Section VII
Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances

Provider Dispute/Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Keystone First – CHIP department.

Informal Provider Disputes Process

Network Providers may request informal resolution of Disputes submitted to Keystone First – CHIP through its Informal Provider Dispute Process.

What is a Dispute?

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a Keystone First – CHIP decision that directly impacts the Provider. Disputes are generally administrative in nature and do not include decisions concerning Medical Necessity. Disputes may focus on issues concerning Keystone First – CHIP services and processes, other Health Care Provider, Enrollees, or claims.

Examples of Disputes include, but are not limited to:

- Service issues with Keystone First – CHIP, including failure by Keystone First – CHIP to return a Network Provider's calls, frequency of site visits by Keystone First – CHIP's Provider Account Executives and/or lack of Provider Network orientation/education by Keystone First – CHIP
- Issues with Keystone First – CHIP processes, including failure to notify Network Providers of policy changes, dissatisfaction with Keystone First – CHIP's Prior Authorization process, dissatisfaction with Keystone First – CHIP's referral process and dissatisfaction with Keystone First – CHIP's Formal Provider Appeals Process
- Contracting issues, including dissatisfaction with Keystone First – CHIP's reimbursement rate, incorrect capitation payments paid to the Network Provider and incorrect information regarding the Network Provider in Keystone First – CHIP's Provider database
- Disputes for denials unrelated to authorization requirements (i.e. coordindation of benefits denials) *

  *Claim denials for authorization requirements not met may be appealed in accordance with the Keystone First – CHIP Formal Provider Appeals Process outlined later in this section.

Filing a Dispute

Network Providers wishing to register a Dispute should contact Provider Claims Services at **1-800-521-6007** or submit the Dispute through NaviNet. Written Disputes should be mailed to the address below and must contain the words "Informal Provider Dispute" at the top of the request:

Keystone First – CHIP
Informal Provider Dispute
P.O. Box 21152
Eagan, MN 55121

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same administrative issue, Keystone First – CHIP has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet and accompanying claims should be sent to the Provider's assigned Account Executive. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet**.

The spreadsheet format can be found online in the Provider Center at **www.keystonefirstchip.com**.

On-Site Meeting

Network Providers may request an on-site meeting with a Provider Account Executive, either at the Network Provider's office or at Keystone First – CHIP to discuss the Dispute. Depending on the nature of the Dispute, the Provider Account Executive may also request an on-site meeting with the Network Provider. The Network Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Dispute with Keystone First – CHIP. The Provider Account Executive assigned to the Network Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Time Frame for Resolution

Keystone First – CHIP will investigate, conduct an on-site meeting with the Network Provider (if one was requested), and issue the informal resolution of the Dispute within sixty (60) calendar days of receipt of the Dispute from the Network Provider. The informal resolution of the Dispute will be communicated to the Network Provider by the same method of communication in which the Dispute was registered (e.g., if the Dispute is registered verbally, the informal resolution of the Dispute is verbally communicated to the Network Provider and if the Dispute is registered in writing, the informal resolution of the Dispute is communicated to the Network Provider in writing). If the informal resolution of the Dispute results in a claim adjustment, the Provider will receive a new explanation of benefits (EOB) for the claim(s) addressed in the dispute.

Relationship of Informal Provider Dispute Process to Keystone First – CHIP's Formal Provider Appeals Process

The purpose of the Informal Provider Dispute Process is to allow Network Providers and Keystone First – CHIP to resolve Disputes registered by Network Providers in an informal manner that allows Network Providers to communicate their Dispute and provide clarification of the issues presented through an on-site meeting with Keystone First – CHIP. Network Providers may appeal most Disputes not resolved to the Provider's satisfaction through the Informal Provider Dispute Process to Keystone First – CHIP's Formal Provider Appeals Process. The types of issues that may not be reviewed through the Keystone First – CHIP Formal Provider Appeals Process are listed in the "Formal Provider Appeals Process" section of this Manual. Appeals must be submitted in writing to Keystone First – CHIP's Provider Appeals Department. Procedures for filing an appeal through Keystone First – CHIP's Formal Provider Appeals Process, including the mailing address for filing an appeal, are set forth in the "Formal Provider Appeals Process" Section. The filing of a Dispute with Keystone First – CHIP's Informal Provider Dispute Process is not a prerequisite to filing an appeal through Keystone First – CHIP's Formal Provider Appeals Process.

In addition to the Informal Provider Dispute Process and the Formal Provider Appeals Process, Health Care Providers may, in certain instances, pursue an Enrollee Complaint or Grievance appeal on behalf of an Enrollee. A comprehensive description of Keystone First – CHIP's Enrollee Complaint and Grievance Process is located in this Section of the Manual. Additionally, information on the relationship with Keystone First – CHIP's Informal Provider Dispute and Formal Provider Appeal Processes can be found in "Relationship of Provider Formal Appeals Process to Provider Initiated Enrollee Appeals" and "Requirements for Grievances filed by Providers on Behalf of Enrollees" in this Section of the Manual.

In order to simplify resolution of Emergency Department payment level issues, which often arise because a claim was submitted without an Emergency Department summary and/or requires a review of medical records, participating hospital Providers are encouraged to address such payment issues through Keystone First – CHIP's informal Emergency Department Payment Level Reconsideration Process before attempting to resolve such issues through the Formal Provider Appeals Process. For complete details see the Claims and Claims Dispute section of the manual.

Provider Appeals Process

Both Network and Non-Participating Providers may request formal resolution of an appeal through Keystone First – CHIP's Formal Provider Appeals Process. This process consists of two levels of review and is described in greater detail below.

What is an Appeal?

An appeal is a written request from a Health Care Provider for the reversal of a denial by Keystone First – CHIP, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through Keystone First – CHIP's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through Keystone First – CHIP's Informal Provider Dispute Process
- Post-service denials for services already rendered by the Health Care Provider to an Enrollee, including denials that:
    - Do not clearly state the Health Care Provider is filing an Enrollee Complaint or Grievance on behalf of an Enrollee (even if the materials submitted with the Appeal contain an Enrollee consent)
    - Require medical necessity review- claim denials for authorization requirements not met.

Examples of appeals include, but are not limited to:

- The Health Care Provider submits a Claim for reimbursement for inpatient services provided at the acute level of care, but Keystone First – CHIP reimburses for a non-acute level of care because the Health Care Provider has not established medical necessity for an acute level of care.
- A Home Care Provider has made a total of ten (10) home care visits but only seven (7) visits were authorized by Keystone First – CHIP. The Home Care Provider submits a Claim for ten (10) visits and receives payment for seven (7) visits.
- Durable Medical Equipment (DME) that requires Prior Authorization by Keystone First – CHIP is issued to an Enrollee without the Health Care Provider obtaining Prior Authorization from Keystone First – CHIP (e.g., bone stimulator). The Health Care Provider submits a Claim for reimbursement for the DME and it is denied by Keystone First – CHIP for lack of Prior Authorization.
- Enrollee is admitted to the hospital as a result of an Emergency Room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital Provider submits a Claim for reimbursement at the one-day acute inpatient rate but Keystone First – CHIP reimburses at the observation rate, in accordance with the hospital's contract with Keystone First – CHIP.
- The Health Care Providers submits a claim for reimbursement for a service that requires prior-authorization, however valid authorization was not obtained prior to the service being rendered.

Types of issues that may not be appealed through Keystone First – CHIP's Formal Provider Appeals Process are:

- Claims denied by Keystone First – CHIP because they were not filed within Keystone First – CHIP's 180-day filing time limit.
- Pre-service denials issued as a result of a Prior Authorization review by Keystone First – CHIP (the review occurs prior to the Enrollee being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the Enrollee, or the Health Care Provider, with written consent of the Enrollee, through Keystone First – CHIP's Enrollee Complaint and Grievance Process outlined in the Section titled Complaints and Grievances for Enrollees.

- Health Care Provider terminations based on quality-of-care reasons may be appealed in accordance with the Keystone First – CHIP Provider Sanctioning Policy outlined in Section VIII; and
- Credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section VIII.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health Care Providers may request a First Level Appeal review by submitting the request in writing within sixty (60) calendar days of: (a) the date of the denial or adverse action by Keystone First – CHIP or the Enrollee's discharge, whichever is later or (b) in the case where a Network Provider filed an Informal Provider Dispute with Keystone First – CHIP, the date of the communication by Keystone First – CHIP of the informal resolution of the Dispute. The request must be accompanied by all relevant documentation the Health Care Provider would like Keystone First – CHIP to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the Post Office Box:

Inpatient & Outpatient Clinical Appeals
Clinical Provider Appeals Department
Keystone First – CHIP
P.O. Box 211352
Eagan, MN 55121

Physician Review of a First Level Appeal

The First Level Appeal Review is conducted by a board-certified Physician employed by Keystone First – CHIP who was not involved in the decision making for the original denial or prior appeal review of the issue. The Physician will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Other available information including but not limited to:
    - Keystone First – CHIP medical and administrative policies
    - Information submitted by the Health Care Provider or obtained by Keystone First – CHIP through investigation
    - The Network Provider's contract with Keystone First – CHIP
    - Keystone First – CHIP's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health Care Providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within sixty (60) calendar days of Keystone First – CHIP's

receipt of the Health Care Provider's request for the First Level Appeal review. If the Health Care Provider is dissatisfied with the outcome of the First Level Appeal review, the Health Care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health Care Providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of Keystone First – CHIP's First Level Appeal determination letter. The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the Health Care Provider would like Keystone First – CHIP to consider during the Second Level Appeal Review.

Requests for a Second Level Appeal Review of an Appeal should be mailed to the Post Office Box below:

Inpatient & Outpatient Clinical Appeals
Clinical Provider Appeals Department
Keystone First – CHIP
P.O. Box 211352
Eagan, MN 55121

Appeals Panel Review of a Second Level Appeal

An external board-certified Physician, who is contracted but not employed by Keystone First – CHIP who was not involved in the decision making for the original denial or prior Appeal review issue will review the appeal. Within five (5) business days the Physician will issue a recommendation to Keystone First – CHIP's Appeals Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of Keystone First – CHIP medical and administrative policies, available information submitted by the Health Care Provider or obtained by Keystone First – CHIP through investigation, the Health Care Provider's contract with Keystone First – CHIP, Keystone First – CHIP's contract with DHS and relevant Medicaid laws, regulations and rules.

Upon receipt of the external Physician's Second Level Appeal recommendation, a written summary of the Second Level Appeal recommendation is submitted to the Appeals Panel, which consists of at least 3 persons and includes ¼ peer representation with Enrollees selected from the following:

- Physician who is employed by Keystone First – CHIP (peer representative).
- Senior Vice President of Provider Network Management or his/her designee;
- Director of Operations or his/her designee; and
- Manager of Appeals or his/her designee.

All supporting documentation submitted at the First Level Appeal review will be available along with the summary of the Appeal, the First Level Appeal outcome and all additional information submitted by the Health Care Provider at the time of the Second Level Appeal request will be presented to all Enrollees of the Appeals Panel in advance of and during the Appeals Panel meeting. The external Physician's recommendation is presented, and the Appeals Panel makes the final decision during the Appeals Panel meeting.

The Appeals Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Other information including but not limited to:
    - Keystone First – CHIP medical and administrative policies
    - Information submitted by the Provider or obtained by Keystone First – CHIP through investigation
    - The Network Provider's contract with Keystone First – CHIP
    - Keystone First – CHIP's contract with DHS and relevant Medicaid laws, regulations and rules

Time Frame for Resolution

Health Care Providers will be notified in writing of the determination of the Second Level Appeal Review within sixty (60) calendar days of Keystone First – CHIP's receipt of the Health Care Provider's request for a Second Level Appeal Review. The outcome of the Second Level Appeal Review is final. Exhaustion of the appeal process is a condition precedent of further remedies.

General Procedures for Enrollees Complaints and Grievances

The following procedures apply to all levels of Complaints and Grievances for Enrollees:

1. Keystone First – CHIP does not charge Enrollees a fee for filing a Complaint or Grievance at any level.
2. Keystone First – CHIP designates and trains sufficient staff to be responsible for receiving, processing, and responding to Enrollee Complaints and Grievances in accordance with applicable requirements and using letter templates supplied by DHS.
3. Keystone First – CHIP staff performing Complaint and Grievance reviews have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.
4. Keystone First – CHIP does not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Enrollee from receiving Medically Necessary care in a timely manner.
5. Keystone First – CHIP accepts Complaints and Grievances from individuals with disabilities in alternative formats, including: TTY/TDD (for telephone inquiries and

Complaints and Grievances from Enrollees who are hearing impaired), Braille, audio tape, computer disk and other commonly accepted alternative forms of communication. Keystone First – CHIP informs employees who receive telephone Complaints and Grievances of the speech limitation of some Enrollees with disabilities so they can treat these individuals with patience, understanding, and respect.

6. Keystone First – CHIP offers Enrollees the assistance of Keystone First – CHIP staff throughout the Complaint and Grievance process at no cost to the Enrollee. Keystone First – CHIP also offers Enrollees the opportunity to be represented by a Keystone First – CHIP staff Enrollee at no cost to the Enrollee.
7. Keystone First – CHIP ensures that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not the subordinate of anyone who was involved in any previous level of review or decision-making in the case at issue.
8. Keystone First – CHIP permits the Enrollee or Enrollee representative (which includes the Enrollee's Health Care Provider), with proof of the Enrollee's written authorization or consent for the representative to be involved and/or act on the Enrollee's behalf, to file a Complaint or Grievance either verbally or in writing. The written authorization or consent must comply with applicable laws, contract requirements and Keystone First – CHIP procedures. Health Care Providers wishing to file a Complaint on behalf of an Enrollee must have the Enrollee's written consent. There are separate consent requirements for Grievances under Act 68 which are not applicable to Complaints. For more information on the specific consent requirements for Grievances, please see the section titled "Requirements for Grievances filed by Providers on Behalf of Enrollees" found in this Section of the Manual.
9. At any time during the Complaint and Grievance process, the Enrollee or their representative may request access to documents, copies of documents, records, and other information relevant to the subject of the Complaint or Grievance. This information is provided at no charge.
10. If Keystone First – CHIP does not decide a First Level Complaint or Grievance within the timeframes specified within the Policy, Keystone First – CHIP notifies the Enrollee and other appropriate parties using a DHS approved letter template. The letter is mailed by Keystone First – CHIP one day following the date the decision on the First Level Complaint or Grievance was to be made.
11. Oral requests for Complaints and Grievances are committed to writing by Keystone First – CHIP and provided to the Enrollee and Enrollee representative for signature through a DHS approved acknowledgement letter. The signature may be obtained at any point in time in the Complaint and Grievance process. If the Enrollee or Enrollee representative's signature is not received, the Complaint or Grievance is not delayed.
12. Keystone First – CHIP provides Enrollees with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Enrollee. This includes: providing qualified sign language interpreters for Enrollees who are severely hearing impaired, providing personal assistance to Enrollees with other physical limitations in copying and presenting documents and other evidence, and providing information submitted on behalf of the Keystone First – CHIP at the Complaint or Grievance review in an alternative format accessible to the Enrollee filing the Complaint or Grievance. The

alternative format version will be supplied to the Enrollee at or before the review, so the Enrollee can discuss and/or refute the content during the review.

13. Keystone First – CHIP provides language interpretation services in the Enrollee's preferred language when requested by an Enrollee, at no cost to the Enrollee.
14. An Enrollee who consents to the filing of a Complaint or Grievance by a Health Care Provider may not file a separate Complaint or Grievance. Keystone First – CHIP will ensure that punitive action is not taken against a Health Care Provider who either requests an Expedited Resolution of a Complaint or Grievance or supports an Enrollee's request for an Expedited Review of a Complaint or Grievance. The Enrollee retains the right to rescind consent throughout the Complaint and Grievance process upon written notice to Keystone First – CHIP and the Health Care Provider.
15. The Enrollee or Enrollee representative has the opportunity to submit written documents, comments or other information relating to the Complaint or Grievance, and to present evidence and testimony and make legal and factual arguments in person, as well as in writing, at both levels of the internal Complaint and Grievance process.
16. Keystone First – CHIP takes into account all information submitted by the Enrollee or Enrollee representative regardless of whether such information was submitted or considered during the initial or prior level of review.
17. Keystone First – CHIP is flexible when scheduling the review to facilitate the Enrollee's attendance. The Enrollee is given at least seven (7) days advance written notice of the review date for First Level Reviews. The Enrollee is given at least fifteen (15) days advance written notice of the review date for Second Level Reviews.
18. If the Enrollee cannot appear in person at the review, Keystone First – CHIP provides the Enrollee with an opportunity to communicate with the committee by telephone. The Enrollee may elect not to attend the review meeting, but the meeting is conducted with the same protocols as if the Enrollee were present.
19. Committee proceedings are informal and impartial to avoid intimidating the Enrollee or Enrollee representative. Persons attending the committee meeting and their respective roles at the review will be identified for the Enrollee and Enrollee representative in attendance.
20. The committee may question the Enrollee and the Enrollee representative, the Health Care Provider and Keystone First – CHIP staff representing Keystone First – CHIP's position.
21. A committee Enrollee who does not personally attend the review may not be part of the decision-making process unless that committee Enrollee actively participates in the review by telephone and has the opportunity to review all information introduced during the review.

Relationship of Provider Formal Appeals Process to Provider Initiated Enrollee Grievances

If a Health Care Provider submits a request for an appeal through Keystone First – CHIP's Grievance Appeals Process and an Enrollee consent has been provided that conforms with applicable law for Act 68 Enrollee Appeals filed by a Health Care Provider on behalf of an Enrollee (specific requirements for Health Care Providers related to Grievances filed by Providers on Behalf of Enrollees are set forth below), the appeal will be processed through the Keystone First – CHIP's Act 68 Enrollee Grievance Process.

If the appeal is processed through the Act 68 Enrollee Grievance Process, the Health Care Provider waives his/her right to file an appeal through Keystone First – CHIP's Formal Provider Appeals Process, unless otherwise specified in the Health Care Provider's contract with Keystone First – CHIP.

If a Health Care Provider, with written consent of the Enrollee, appeals a denial through the Act 68 Enrollee Grievance Process at any time prior to or while the Formal Provider Appeal is pending, the Formal Provider Appeal will be terminated and the Formal Provider Appeal closed. Keystone First – CHIP will notify the Health Care Provider in writing if a Formal Provider Appeal has been closed for this reason.

Requirements for Grievances filed by Providers on Behalf of Enrollees

Enrollee Consent Requirements for Grievances

Pennsylvania Act 68 gives Health Care Providers the right, with the written permission of the Enrollee, to pursue a Grievance on behalf of an Enrollee. A Health Care Provider may ask for an Enrollee's written consent in advance of treatment but may not require an Enrollee to sign a document allowing the filing of a Grievance by the Health Care Provider as a condition of treatment. There are regulatory requirements for Health Care Providers that specify items that must be in the document giving the Health Care Provider permission to pursue a Grievance on behalf of an Enrollee, and the time frames to notify Enrollees of the Health Care Provider's intent to pursue or not pursue a Grievance on behalf of an Enrollee. These requirements are important because the Health Care Provider assumes the Grievance rights of the Enrollee.

The Enrollee may rescind the consent at any time during the Grievance process. If the Enrollee rescinds consent, the Enrollee may continue with the Grievance at the point at which consent was rescinded. The Enrollee may not file a separate Grievance for the same issue listed in the consent form signed by the Enrollee which the Health Care Provider is pursuing. An Enrollee who has filed a Grievance may, at any time during the Grievance process, choose to provide consent to a Health Care Provider to continue with the Grievance instead of the Enrollee. The Enrollee's consent is automatically rescinded upon the failure of the Health Care Provider to file or pursue a Grievance on behalf of the Enrollee. The Health Care Provider, having obtained consent from the Enrollee or the Enrollee's legal representative to file a Grievance, has 10 days from receipt of the Medical Necessity denial and any decision letter from a First, Second or External Review upholding

Keystone First – CHIP's decision to notify the Enrollee or the Enrollee's legal representative of his or her intention not to pursue a Grievance.

It is important for Health Care Providers to remember they may not bill Keystone First – CHIP Enrollees for covered services. If a Health Care Provider assumes responsibility for filing a Grievance and the subject of the Grievance is for non-covered services provided, then the Health Care Provider may not bill the Enrollee until the External Grievance Review is completed or the Enrollee rescinds consent for the Health Care Provider to pursue the Grievance. If the Health Care Provider chooses to never bill the Enrollee for non-covered services that are the subject of the Grievance, the Health Care Provider may drop the Grievance with notice to the Enrollee.

The consent document giving the Health Care Provider authority to pursue a Grievance on behalf of an Enrollee shall be in writing and must include each of the following elements:

- The name and address of the Enrollee, the Enrollee's date of birth, and the Enrollee's identification number.
- If the Enrollee is a minor, or is legally incompetent, the name, address and relationship to the Enrollee of the person who signs the consent for the Enrollee.
- The name, address and identification number of the Health Care Provider to whom the Enrollee is providing the consent.
- The name and address of the plan to which the Grievance will be submitted.
- An explanation of the specific service for which coverage was provided or denied to the Enrollee to which the consent will apply.
- The following statements:
    - The Enrollee or the Enrollee's representative may not submit a Grievance concerning the services listed in this consent form unless the Enrollee or the Enrollee's legal representative rescinds consent in writing. The Enrollee or the Enrollee's legal representative has the right to rescind consent at any time during the Grievance process.
    - The consent of the Enrollee or the Enrollee's legal representative is automatically rescinded if the Health Care Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the Review Process.
    - The Enrollee or the Enrollee's legal representative, if the Enrollee is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Enrollee, or the Enrollee's legal representative understands the information in the Enrollee's consent form.
- The consent document must also have the dated signature of the Enrollee, or the Enrollee's legal representative if the Enrollee is a minor or is legally incompetent, and the dated signature of a witness.

Note: The Pennsylvania Department of Health has developed a standard Enrollee (Enrollee) consent form that complies with the provisions of Act 68. The form can be found at under

"Provider Initiated Grievance and Enrollee Consent Form" on the Pennsylvania Department of Health website or in Appendix VI of the Provider Manual.

Escrow Requirements for External Grievances (Including Expedited External Grievances)

If a Health Care Provider requests an External Grievance Review, the Health Care Provider and Keystone First – CHIP must each establish escrow accounts in the amount of half the anticipated cost of the review. The Health Care Provider will be given more specific information about the escrow requirement at the time of the filing of the External Grievance. If the External Grievance Decision is against Keystone First – CHIP, in part or in full, Keystone First – CHIP pays the cost. If the decision is against the Enrollee, in part or in full, Keystone First – CHIP pays the cost. If the decision is against the Health Care Provider in full, the Health Care Provider pays the cost.

Section VIII
Quality Assessment Performance Improvement, Credentialing, and Utilization Management

Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPI) is an integrative process that links together the knowledge, structure and processes throughout a Managed Care Organization to assess and improve quality. This process also assesses and improves the level of performance of key processes and outcomes within an organization. Opportunities to improve care and service are found primarily by examining the systems and processes by which care, and services are provided.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure for the continuous monitoring, evaluation, and improvement in care and service. The QAPI Program is broad in scope and encompasses the range of clinical and service issues relevant to Enrollees. The scope includes quality of clinical care, quality of service, and preventive health services. The QAPI Program continually monitors and reports analysis of aggregate data, intervention studies and measurement activities, programs for populations with Special Healthcare Needs and surveys to fulfill the activities under its scope. The QAPI Program centralizes and uses performance monitoring information from all areas of the organization and coordinates quality improvement activities with other departments.

Objectives

The objectives of the QAPI Program are to systematically develop, monitor and assess the following activities:

- Maximize utilization of collected information about the quality of clinical care and service and to identify clinical and service improvement initiatives for targeted interventions.
- Ensure adequate practitioner and Provider availability and accessibility to effectively serve the Enrollee.
- Maintain credentialing/recredentialing processes to assure that the Managed Care Organization's network is comprised only of qualified practitioners/Providers.
- Oversee the functions of delegated activities.
- Continue to enhance physician profiling process and optimize enhanced systems to communicate performance to participating practitioners.
- Coordinate services between various levels of care, Network Providers, and community resources to assure continuity of care.
- Optimize Utilization Management to assure that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards.
- To ensure that Enrollee benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization.
- Utilize Enrollee and Network Provider satisfaction study results when implementing quality activities.

- Implement and evaluate Disease Management programs to effectively address chronic illnesses affecting the Enrollee.
- Maintain compliance with evolving National Committee for Quality Assessment (NCQA) accreditation standards.
- Communicate results of our clinical and service measures to Network Providers, and Enrollees.
- Identify, enhance and develop activities that promote Enrollee safety.
- Document and report all monitoring activities to appropriate committees.

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the QM Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives

QAPI Program effectiveness is evaluated on an annual basis. This assessment allows Keystone First – CHIP to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to the Keystone First – CHIP Enrollee. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QI work plan. Feedback and recommendations from various committees are incorporated into the evaluation.

Quality Assessment and Performance Improvement Program Authority and Structure

Keystone First – CHIP's Quality Assessment and Performance Improvement Committee (QAPIC) provides leadership in Keystone First – CHIP's efforts to measure, manage and improve quality of care and services delivered to Enrollees and to evaluate the effectiveness of Keystone First – CHIP's QAPI Program through measurable indicators. All other quality-related committees report to the QAPIC.

Other quality-related committees include the following:

Credentialing Committee

The Credentialing Committee is a peer review committee whose purpose is to review Providers' credentialing/recredentialing application information in order to render a decision regarding qualification for the Enrollee to Keystone First – CHIP's Network.

Pharmacy and Therapeutics (P&T) Subcommittee

The P&T Subcommittee is responsible for evaluating the clinical efficacy, safety, and cost-effectiveness of medications in the treatment of disease states through product evaluation and drug Formulary recommendations. The Subcommittee also uses drug prescription patterns to develop Network Provider educational programs.

Quality Assessment and Performance Improvement Committee (QAPIC)

The Quality Assessment and Performance Improvement Committee (QAPIC) coordinates the Keystone First – CHIP's efforts to measure manage and improve quality of care and services delivered to Keystone First – CHIP Enrollees and evaluates the effectiveness of the QAPI Program. It is responsible for directing the activities of all clinical care delivered to Enrollees.

Quality of Service Committee (QSC)

The QSC is responsible for measuring and improving services rendered to Enrollees and Providers in the Enrollee Services, Claims, Provider Services, and Provider Network Management Departments.

Operational Compliance Committee

The purpose of the Operational Compliance Committee (OCC) is to assist the Chief Compliance Officer and the Privacy Officer with the implementation and maintenance of the Corporate Compliance and Privacy Programs.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, Enrollees' and Health Care Providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Credentialing/Recredentialing Requirements

Practitioner Requirements

Keystone First – CHIP maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and NCQA accreditation standards governing credentialing and recredentialing functions.

The following types of practitioners require initial credentialing and recredentialing (at a minimum of every 36 months):

- Audiologist (AUD)
- Chiropractor (DC)
- Certified Nurse Midwife (CNM)
- Certified Nurse Practitioner (CRNP/APN)
- Dentist (DDS and DMD) (including General Dentists and Pediatric Dentists)
- Doulas (N/A)
- Licensed Clinical Social Worker (LCSW)

- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Medical Doctor (MD and DO) (Including Psychiatrists)
- Occupational Therapist (OT)*
- Oral Surgeon (DDS)
- Pharmacists (authorized to administer injectables only)
- Physical Therapist (PT)
- Podiatrist (DPM)
- Psychologist (Ph.D)
- Speech and Language Therapist (SLP)*
- Therapeutic Optometrist (OD)
- Registered Dietician (RD)

*Only private practice (practitioners who have an independent relationship with Keystone First – CHIP) require credentialing.

Hospital based practitioners practicing exclusively in the inpatient setting are not credentialed or recredentialed by the Health Plan. Hospital based practitioners are defined as, but not limited to Pathologists, Anesthesiologists, Radiologists, Emergency Medicine, Neonatologists, and Hospitalists.

Locum tenens employed by a healthcare system or a hospital would be required to be credentialed by that organization or for that organization by another credible body. If the Provider will be serving for a longer term, greater than 60 days, and credentialing is not delegated to the organization, or its surrogate, Keystone First – CHIP will credential those locum tenens identified by the organization.

The following criteria must be met as applicable, in order to evaluate a qualified Health Care Practitioner:

- **A current, active and unrestricted Individual Medicaid number** along with service location numbers for each address contracted with Keystone First – CHIP (applications submitted without an active Medicaid or PPID number must be accompanied by a signed and dated copy of the enrollment application; individual and/or service location applications)
- **An individual and group NPI number**
- A current unrestricted state license, not subject to probation, proctoring requirements or disciplinary action. A copy of the license must be submitted along with the application
- A valid DEA certificate, if applicable. The DEA certificate must have an address listed in the State where the practitioner is treating Enrollees. The DEA certificate is non-transferrable by location. If the practitioner has chosen not to prescribe, they must submit a letter notifying us that they will not be prescribing and have not obtained a DEA license

- Education and training that supports the requested specialty or service, as well as the degree credential of the Health Care Practitioner
- Foreign trained Health Care Providers must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number within the application
- Board Certification Certificate, if applicable or National Certification Certificate for CRNPs/PAs, if applicable
- The following board organizations are recognized by Keystone First – CHIP for purposes of verifying specialty board certification:
    - American Board of Medical Specialties – ABMS
    - American Medical Association – AMA
    - American Osteopathic Association – AOA
    - American Board of Foot and Ankle Surgery - ABFS- ABPS
    - American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
    - Royal College of Physicians and Surgeons
- Work history containing current employment, as well as explanation of any gaps greater than six months within the last (5) years
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Health Care practitioner in the past 5 years
- A current copy of the professional liability insurance face sheet (evidencing coverage – minimum coverage amount of $500,000/$1.5million with excess coverage of $500,000/$1.5 million) – total coverage should equal $1million/$3 million. Malpractice insurance may also be listed on the application in lieu of a face sheet as long as the effective date, expiration date, policy number, and limits of liability are included on the application. A Federal Tort Letter is also acceptable insurance.
- Hospital admitting arrangements (for Primary Care Providers (PCPs)) with an institution participating with Keystone First – CHIP or, as an alternative, those Health Care practitioners who do not have admitting hospital privileges, may enter into an admitting arrangement with a participating Health Care practitioners(s) who has admitting privileges at a participating hospital. Those practitioners who do not have admitting privileges may also utilize a hospitalist service at a Keystone First – CHIP participating hospital.
- Collaborative Agreement for CRNP's and CNM's with a Supervising physician who is a Keystone First – CHIP participating physician
- Explanation to any affirmative answers on the “General Questions” section of the application
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable. CLIA certificate is required for all addresses where the practitioner has laboratory services in the office where Keystone First – CHIP Enrollees are being treated; and
- Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or other appropriate professional organization

Practitioner Application

Keystone First – CHIP offers practitioners the Universal Provider Datasource through an agreement with The Council for Affordable Quality Healthcare (CAQH) that simplifies and streamlines the data collection process for credentialing and recredentialing.

Through CAQH, credentialing information is provided to a single repository, via a secure internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to practitioners to participate in CAQH or to submit applications. Keystone First – CHIP encourages all practitioners to utilize this service.

Submit your application to participate with Keystone First – CHIP via CAQH (**www.caqh.org**):

- Register for CAQH
- Grant authorization for Keystone First – CHIP to view your information in the CAQH database
- Send your CAQH ID number to Keystone First – CHIP at **credapps@keystonefirstpa.com**

Keystone First – CHIP Paper Application Process

- Complete a PA Standard application and attestation that includes the practitioner's signature and current date
- Sign and date a release of information form that grants permission to contact outside agencies to verify or supply information submitted on the applications
- Submit all License, DEA, Board Certification, Education and Training, Hospital Affiliation and other required information with the application, which will be verified directly through the primary sources prior to the credentialing/recredentialing decision
- Submit a **PROMISe™**/Medicaid number issued by DHS along with the PPID/Service Location number for all addresses where the practitioner will be rendering services to Keystone First – CHIP Enrollees. If the Medicaid PPID number has not yet been received, a signed and dated copy of the PPID enrollment application must be submitted along with the credentialing/recredentialing application.

As part of the application process, Keystone First – CHIP will:

- Request information on Health Care practitioner sanctions prior to making a credentialing or recredentialing decision. Information from the National Practitioner Data Bank (NPDB), Medicheck (Medicaid exclusions), HHS Office of Inspector General (Medicaid/Medicare exclusions) through Streamline Verify, System for Awards Management (SAM) through Streamline Verify, Federation of Chiropractic Licensing Boards (CIN-BAD), Excluded Parties List System (EPLS) , Social Security Death Master File (SSDMF) through Streamline Verify, and Pennsylvania State Disciplinary Action report will be reviewed as applicable

- Perform primary source verification on required items submitted with the application as required by the National Committee for Quality Assessment (NCQA), State and Federal regulations
- Performance review of complaints, quality of care issues and utilization quality concerns will be reviewed quarterly by the Quality Management Department. A summary of their review will be presented at the QAPI meeting. A Quality Recredentialing Profile will also be completed for all practitioners and Providers due for recredentialing and will be presented to the Credentialing Committee as necessary.
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

Presentation to the Medical Director or Credentialing Committee:

Once all information is received and primary source verifications are completed the practitioner's file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director
- All non-routine (i.e., malpractice cases, license sanctions, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination

After the submission of the application, Health Care Practitioners:

- Have the right to review the information submitted to support their credentialing/recredentialing application, with the exception of recommendations, and peer protected information obtained by Keystone First – CHIP.
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the practitioner provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy. The practitioner will have 10 business days from the date of the notification to correct the erroneous information. The practitioner can submit the correction either by email, fax, or phone to the Credentialing department. Corrections received by phone will be documented in the Credentialing database by the Credentialing department.
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application. The Credentialing Department will share all information with the practitioner with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the practitioner.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision

- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision

*To request or provide information for any of the above, the practitioner should contact Keystone First – CHIP's Credentialing Department at the following address:

Attn: Credentialing Department
Keystone First – CHIP
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-833-806-2733
Fax: 1-833-704-1182

Facility Requirements

Facility Providers must meet the following criteria:

- Keystone First – CHIP will confirm that the facility is in good standing with all state and regulatory bodies and has been reviewed by an accredited body as applicable. If there are no accreditation status results, a current CMS State Survey will be accepted. If the Facility is not accredited and does not have a CMS State Survey, Keystone First – CHIP's Provider Network Management Department will schedule a site visit of the facility. Recertification of facilities must occur a minimum of every 36 months.
- The following types of facilities are credentialed and recertified:
    - Hospitals (acute care and acute rehabilitation)
    - Free Standing Psychiatric Hospitals
    - Skilled Nursing Facilities (SNF)
    - Skilled Nursing Facilities providing sub-acute services
    - Nursing Homes
    - Sub-Acute Facilities
    - Outpatient Rehabilitation Facilities
    - Mental Health Outpatient Clinics
    - Mental Health Partial Hospitalization Programs
    - Home Health Agencies
    - Hospice
    - Ambulatory Surgical Center (ASC)
    - Durable Medical Equipment
    - Dialysis Centers
    - Free Standing Sleep Centers/Sleep Labs
    - Free Standing Radiology Centers
    - Diabetic Education Programs
    - Portable X-ray Suppliers/Imaging Centers
    - Intensive Behavioral Health Services (Applied Behavioral Analysis)
    - Substance Use Outpatient Clinics
    - Substance Use Intensive Outpatient Clinics

  - Substance Use Partial Hospitalization Programs
  - Substance Use Residential Programs including Withdrawal Management
- The following information must be submitted with the credentialing application: A current copy of the facility's unrestricted license not subject to probation, suspension, or other disciplinary action
- A current copy of the facility's malpractice coverage and history of liability
- A current copy of the accreditation certificate or letter or current CMS State Survey, if applicable (if the facility is not accredited and has not had a CMS State Survey, or letter from CMS, or if the most recent survey is older than 3 years old at the time of verification, Keystone First – CHIP's Provider Network Management Department will schedule a site visit of the facility)
- The facility must submit a **PROMISe™**/Medicaid ID number issued by DHS under which services will be rendered, If the facility is not yet enrolled, a signed and dated copy of the enrollment application to DHS must be submitted with the application.
- The facility must submit an active Medicare number if applicable
- The facility must submit a Group NPI number
- Ownership Disclosure Form if applicable

Facility Application

Facilities must:

- Complete the facility application with signature and current date from the appropriate facility officer. A facility application must be completed for each location where the Provider renders services to Keystone First – CHIP Enrollees. Supporting documents noted above must be provided for each location.
  - **Note:** A parent facility with branch locations is required to submit one application listing all addresses. A copy of one license, accreditation or CMS State Survey, and malpractice insurance is also required. Proof that additional locations are branch locations must also be provided (this is usually documented on the Accreditation Certificate or CMS State Survey).

- Attest to the accuracy and completeness of the information submitted to Keystone First – CHIP
- Submit documentation of any history of disciplinary actions, loss or limitation of license, Medicare/Medicaid sanctions, or loss, limitation, or cancellation of professional liability insurance

Keystone First – CHIP will:

- Verify the facility's status with state regulatory agencies through the State Department of Health
- Request information on facility sanctions prior to rendering a credentialing or recredentialing decision, by obtaining information from the National Practitioners Data Bank (NPDB)/ Medicheck (Medicaid exclusions), HHS Office of Inspector General (Medicaid/Medicare exclusions) through Streamline Verify, and System for Award Management (SAM) through Streamline Verify.

- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing.
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees.

After the submission of the application, Facilities:

- Have the right to review the information submitted to support their credentialing/recertification application, with the exception of recommendations, and peer protected information obtained by Keystone First – CHIP; *
- Have the right to correct erroneous information. When information is obtained by the Credentialing Department that varies substantially from the information the Provider provided, the Credentialing Department will notify the Health Care Provider to correct the discrepancy. The Provider will have 10 business days to correct the erroneous information;
- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application.* The Credentialing Department will share all information with the Provider with the exception of references, recommendations or peer-review protected information (i.e., information received from the National Practitioner Data Bank). Requests can be made via phone, email, or in writing. The Credentialing Department will respond to all requests within 24 business hours of receipt. Responses will be via email or phone call to the Provider.
- Have the right to be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision; and,
- Have the right to appeal any credentialing/recredentialing denial within 30 calendar days of receiving written notification of the decision.

*To request or provide information for any of the above, the Provider should contact Keystone First – CHIP's Credentialing Department at the following address:

Attn: Credentialing Department
Keystone First – CHIP
200 Stevens Drive
Philadelphia, PA 19113
Phone: 1-833-806-2733
Fax: 1-215-863-6369

Presentation to the Medical Director or Credentialing Committee:
Once all information is received and primary source verifications are completed the facility file is presented to either the Medical Director or Credentialing Committee for review and determination.

- All routine (clean) files are presented daily to the Medical Director
- All non-routine (i.e., malpractice cases, sanctions, CMS State Survey discrepancies, etc.) files are presented to the monthly Credentialing Committee meeting for review, discussion, and determination

All practitioners and facilities are required to be recredentialed or recertified at a minimum of every 36 months. All items noted in the Credentialing section are required at the time of recredentialing or recertification, with the exception of work history and education for practitioners. All primary source verifications noted above are conducted at the time of recredentialing and recertification. Presentation to the Medical Director or Credentialing Committee occurs for recredentialing and recertification files as noted above.

Enrollee Access to Physician Information

Enrollees can call Enrollee Services to request information about Network Providers, such as where they went to medical school, where they performed their residency, and if the Network Provider is board-certified.

Provider Sanctioning Policy

It is the goal of Keystone First – CHIP to assure Enrollees receive quality health care services. In the event that health care services rendered to an Enrollee by a Network Provider represent a serious deviation from, or repeated non-compliance with, Keystone First – CHIP's quality standards, and/or recognized treatment patterns of the organized medical community, the Network Provider may be subject to Keystone First – CHIP's formal sanctioning process.

Prohibition on Payment to Excluded/Sanctioned Persons

In addition, pursuant to section 1128A of the Social Security Act and 42 CFR 1001.1901, Keystone First – CHIP may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs.

A Sanctioned Person is defined as any person or affiliate of a person who is (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; or (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification.

Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletin (MAB) 99-11-05 requires all Providers who participate in Medicare, Medicaid or any other federal health care program to screen **their employees and contractors, both individuals and entities, before employing or contacting with** them and to rescreen all employees on an on-going monthly basis, to determine if they have been excluded from participation in any of the aforementioned programs.

Examples of individuals (as outlined in MAB 99-11-05) that should be screened include, but are not limited to the following:

- An individual or entity who provides a service for which a claim is submitted to Medicaid;
- An individual or entity who causes a claim to be generated to Medicaid;
- An individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as Providers who send a Medicaid recipient to another Provider for additional services or second opinion related to a medical condition.

All federal health care programs, including Keystone First – CHIP are prohibited from paying for any items or services furnished, ordered, directed or prescribed by excluded individuals or entities.

To access DHS Medical Assistance Bulletins (MABs) **visit www.pa.gov/agencies/dhs → Resources & Information → For Providers → Bulletin Search** or on the Keystone First - CHIP Provider Center at **www.keystonefirstchip.com → Providers → Resources → Communications → Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletins.**

Resources:
Pennsylvania Medicheck List is a data base maintained by DHS that identifies Providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program: **https://www.pa.gov/agencies/dhs/report-fraud/medicheck-list**

List of Excluded Individuals/Entities (LEIE) is a database maintained by HHS- OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although DHS makes best efforts to include on the Medicheck List all federally excluded individuals/entities that practice in Pennsylvania, Providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program: **https://oig.hhs.gov/exclusions/index.asp**

The System for Award Management (SAM) is an official website of the U.S. government to search for entity registration and exclusion records: **https://oig.hhs.gov/exclusions/index.asp**

Upon request of Keystone First – CHIP, a Provider will be required to furnish a written certification to Keystone First – CHIP that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

A Provider is required to immediately notify Keystone First – CHIP upon knowledge that any of its contractors, employees, directors, officers or owners have become an Excluded Person or is under any type of investigation which may result in a state and/or federal exclusion. In the event that a Provider cannot provide reasonably satisfactory assurance to Keystone First – CHIP that an

Excluded Person will not receive payment from Keystone First – CHIP under the Provider Agreement, Keystone First – CHIP may immediately terminate the Provider Agreement. Keystone First – CHIP reserves the right to recover all amounts paid by Keystone First – CHIP for items or services furnished by an Excluded Person.

All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When the Keystone First – CHIP Quality Department identifies a potential quality concern regarding care and/or services being delivered by a Network Provider the clinical information is presented the plan's Medical Director. The Medical Director may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

- The Quality Management Department sends a letter of notification to the Network Provider. The letter will describe the quality concerns and outlines what actions are recommended for correction of the concern. The Network Provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the Network Provider must correct the concern.

The letter is to be clearly marked:
Confidential: Product of Peer Review

- The Network Provider is required to respond to the request within the timeframe indicated in the notification.
- Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, Keystone First – CHIP's quality standards, and/or recognized treatment patterns of the organized medical community, the Keystone First – CHIP Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The Network Provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the Network Provider of his/her right to a hearing before a hearing panel.
- The Network Provider's current Enrollee panel (if applicable) and referrals and/or admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The Network Provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action
- That the Network Provider has the right to request a hearing on the proposed action
- That the Network Provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The Network Provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The Network Provider may waive his/her right to a hearing

Notice of Hearing

If the Network Provider requests a hearing in a timely manner, the Network Provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the Network Provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of Keystone First – CHIP and/or upon the advice of Keystone First – CHIP's Legal Department
- A list of witnesses (if any) expected to testify at the hearing on behalf of Keystone First – CHIP

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by Keystone First – CHIP
- Individuals on the panel will not be in direct economic competition with the Network Provider involved, nor will they have participated in the initial decision to propose Sanctions
- The panel will be composed of physician Enrollees of the Keystone First – CHIP's Quality Committee structure, the CMO of Keystone First – CHIP, and other physicians and administrative persons affiliated with Keystone First – CHIP as deemed appropriate by the CMO of Keystone First – CHIP. The Keystone First – CHIP CMO or his/her designee serves as the hearing officer
- The right to the hearing will be forfeited if the Network Provider fails, without good cause, to appear

Provider's Rights at the Hearing

The Network Provider has the right:

- To representation by an attorney or other person of the Network Provider's choice
- To have a record made of the proceedings (copies of which may be obtained by the Network Provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing

- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s)
- To receive the Plan's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the Keystone First – CHIP Peer Review Committee

The Network Provider may request an appeal after the final decision of the Panel

- The Keystone First – CHIP Quality Improvement Committee must receive the appeal by certified mail within 30 days of the Network Provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited
- Written appeal will be reviewed and a decision rendered by the Keystone First – CHIP Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal

Summary Actions Permitted

The CEO, President of PA Managed Care, the Executive Vice President and Chief Operating Officer, and/or the CMO, can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action
- Immediate revocation, in whole or in part, of panel membership or Network Provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action

External Reporting

The CMO will direct the Credentialing Department to prepare an adverse action report for submission to the National Practitioner Data Bank (NPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a Network Provider will materially affect Keystone First – CHIP's ability to make available all capitated services in a timely manner, Keystone First – CHIP will notify DHS of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) involves the planning, organizing, directing, and monitoring of delegated and non-delegated health care services. These activities are to ensure the provision of appropriate, affordable, high-quality care, contributing to the overall goal of Enrollee wellness and are one mechanism by which Keystone First – CHIP seeks to reduce inappropriate and duplicative use of health care services. Utilization management activities and results are reported to the

Quality Assessment and Performance Improvement Committee (QAPIC) and reflect monitoring activities stated in the Quality Assessment Performance Improvement (QAPI) Program. UM Program policies and procedures meet NCQA standards and are reviewed and updated annually and more frequently as needed.

Annual Review

Annually, Keystone First – CHIP reviews and updates its UM and policies and procedures as applicable. These modifications, which are approved by the Keystone First – CHIP Medical Management Committee, are based on, among other things, changes in laws, regulations, DHS requirements, accreditation requirements, industry standards and feedback from Health Care Providers, Enrollees and others.

Mission and Values

The Keystone First – CHIP UM program establishes a process for implementing and maintaining an effective, efficient utilization management program. Utilization management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to Enrollees within the structure of their benefit plan. Utilization management, and integrated Population Health Care management work together to facilitate communication of Enrollee's health status, needs, and coordination of care between Providers involved in the Enrollee's care.

Keystone First – CHIP utilization management plan applies to:

- Medical, and behavioral health/substance use disorder services.
- All Enrollees population, age groups, disease categories and special risk groups enrolled in Keystone First – CHIP, regardless of eligibility category.
- All covered services provided to Enrollees through contracted or non-contracted practitioners and Providers.
- All sites and facilities in-state and out-of-state (including ancillary providers) at which contracted and/or non-contracted practitioners provide care or services to Enrollees.
- All processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage and medical appropriateness including:
    - Utilization Management processes and functions: prior authorization, concurrent review, discharge planning, and care management.
    - Utilization monitoring processes (e.g., over/under utilization of services, drug utilization reviews).
    - Performance monitoring process (e.g., inter-rater reliability, telephone answer time, abandonment rate, productivity, decision notification timeframes.)
    - Evaluation of outcome data.

Criteria Availability

Keystone First – CHIP has adopted clinical practice guidelines for use in guiding the treatment of Enrollees, with the goal of reducing unnecessary variations in care. The clinical practice guidelines

represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The following complete clinical practice guidelines are available upon request by calling the Provider Services Department or by visiting the Provider Center of our website at **www.keystonefirstchip.com**:

Acute Pharyngitis in Children	Hemophilia
Asthma	HIV
Chlamydia	Hypertension
Cholesterol	Immunizations and Screenings
Chronic and Obstructive Pulmonary Disease	Maternity
Diabetes	Preventive Health Guidelines
Heart Failure	Sickle Cell

Keystone First – CHIP will provide its Utilization Management (UM) criteria to Network Providers upon request. To obtain a copy of the Keystone First – CHIP UM criteria:

- Call Enrollee Services at **1-844-472-2447**
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within 5 business days of your request.

Please remember that Keystone First – CHIP has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. Call the Peer-to-Peer Hotline at: **1-833-762-4727**.

Additionally, Keystone First – CHIP would like to remind Health Care Providers of our affirmation statement regarding incentives:

- UM decision-making is based only on appropriateness of care and the service being provided
- Keystone First – CHIP does not reward Health Care Providers or other individuals for issuing denials of coverage or service
- There are no financial incentives for UM decision makers to encourage underutilization

Hours of Operation

A toll-free number (**1-877-486-2447**) is available for Providers to contact the Plan's UM staff. The UM Department is available to answer calls during normal business hours, 8:30 a.m. - 5:00pm. Translation services are available as needed.

After business hours and on weekends and holidays, Health Care Providers are instructed to contact the On-Call Nurse through the Keystone First – CHIP's Enrollee Services number **1-844-472-2447.** After obtaining key contact and Enrollee information, the Enrollee Service Representative pages the on-call Nurse. The on-call Nurse contacts the Health Care Provider, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse is responsible to contact the requesting Health Care Provider and when applicable, the Enrollee with the outcome of their request.

Utilization Management Inpatient Stay Monitoring

The Utilization Management (UM) Department is mandated by the Department of Human Services to monitor the progress of an Enrollee's inpatient hospital stay. This is accomplished by the UM Department through the review of appropriate Enrollee clinical information from the Hospital. Hospitals are required to provide Keystone First – CHIP, within two (2) business days from the date of an Enrollee's admission (unless a shorter timeframe is specifically stated elsewhere in the Provider Manual), all appropriate clinical information that details the Enrollee's admission information, progress to date, and any pertinent data.

As a condition of participation in the Keystone First – CHIP Network, Providers must agree to the UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the Keystone First – CHIP Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, Keystone First – CHIP must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances" in Section VIII of the Manual.

Timeliness of Utilization Management Decisions

Several external standards guide Keystone First – CHIP's timeline standards. These include NCQA, DHS, Pennsylvania's Act 146 and accompanying regulations, and other applicable state and federal laws and regulations. Where standards conflict, Keystone First – CHIP adopts the more rigorous of the standards. Table 1 identifies Keystone First – CHIP's timeliness standards.

Table 1: Timeliness of UM Decisions – Excludes Pharmacy

Case Type	Decision	Initial Notification	Written Confirmation*
Urgent Precertification	24 hours from receipt of request**	24 hours from receipt of request	2 business days after decision is made
Non-Urgent Precertification	2 business days from receipt of the request **	2 business days from receipt of the request	2 business days after decision is made
Concurrent Review	1 business day from receipt of the request**	1 business day from receipt of the request	2 business days after decision is made
Retrospective Review***	30 calendar days from receipt of the records	30 calendar days from receipt of the records	2 business days after decision is made
Home Health Services	48 hours from receipt of the request	48 hours from receipt of the request	48 hours from receipt of the request

* *Written confirmation is provided for all cases where coverage for the requested service is partially or completely denied.*

** *The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the Enrollee and requesting Health Care Provider are notified of the required information in writing (not applicable to retrospective review).*

*** *Retrospective Review requests are to be received no later than 180 days from the date of service.*

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Provider Dispute/Appeal Procedures; Enrollee Complaints and Grievances" in Section VIII of the Manual.

Denial and Appeal Process

Medical necessity denial decisions made by a Medical Director, or other physician designee, are based on the DHS definition of Medically Necessary, in conjunction with the Enrollee's benefits, applicable MA laws and regulations, the Medical Director's medical expertise, medical necessity criteria, as referenced above, and/or published peer-review literature. At the discretion of the Medical Director, in accordance with applicable laws, regulations or other regulatory and accreditation requirements, input to the decision may be obtained from participating board-certified physicians from an appropriate specialty. The Medical Director or physician designee makes the final decision. Prior authorization is not a guarantee of payment for the service(s) authorized. Keystone First – CHIP reserves the right to adjust any payment made following a review of the medical record and determination of medical necessity of the services provided.

Upon request of an Enrollee or Network Provider, the criteria used for making Medically Necessary decisions is provided, in writing, by the Medical Director or physician designee.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, Keystone First – CHIP's physician reviewers are available to discuss the decision with the practitioner. A call to discuss the determination is accepted from the Practitioner:

- Within 5 business days of the verbal/faxed denial notification.
- Up to 5 business days after a determination for a Prior (Pre-Service) request has been rendered
- Up to 5 business days after a determination of a retrospective review has been rendered, whichever is later

If you receive a medical necessity denial of services, contact UM **1-877-486-2447** and follow the prompts. An intake representative will take your information and communicate it to the physician. The physician will attempt to contact the requesting provider based on the agreed timeframe and physician availability. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal. For information on the types of issues that may be the subject of a Formal Provider Appeal, please see Section VII.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, DHS requirements and Department of Health requirements. Denial letters are available in other preferred languages and formats upon request. This service is available through the cooperation of Enrollee Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the Enrollee's rights to appeal and the processes for filing appeals through the Keystone First – CHIP Complaint and Grievance Process. Enrollees contact the Enrollee Service Unit to file Complaint and Grievance appeals where an Enrollee advocate is available to assist Enrollees as needed.

Evaluation of New Technology

When Keystone First – CHIP receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or DHS technology assessment group guidelines. Keystone First – CHIP Medical Directors make the final determination on coverage.

Evaluation of Enrollee & Provider Satisfaction and Program Effectiveness

Not less than every two years, the UM department completes an analysis of Enrollee and Network Provider satisfaction with the UM program. At a minimum, the sources of data used in the

evaluation include the annual Enrollee satisfaction survey, Enrollee Complaints and Grievances, and Provider Network surveys and complaints.

To support its objective to create partnerships with physicians, Keystone First – CHIP actively seeks information about Network Provider satisfaction with its programs on an ongoing basis. In addition to monitoring Health Care Provider complaints, Keystone First – CHIP holds meetings with Network Providers to understand ways to improve the program.

Monthly, the department reports telephone answering response, abandonment rates and decision time frames.

Section IX

Special Healthcare Needs and Care Management

Population Health Management (PHM)

The Care Management program is a population-based health management program that utilizes a blended model that provides comprehensive care management and disease management services and care coordination to the highest risk health plan Enrollees. The primary focus is on coordination of resources for those Enrollees expected to experience adverse events in the future and assisting Enrollees with complex medical needs. The voluntary program provides specialized services which support and assist Enrollees with medical, behavioral and/or social issues that impact their quality of life and health outcomes. Identified issues/diagnoses that would result in a referral to a care management program include, but are not limited to:

- Asthma
- Behavioral Health
- Diabetes
- Multiple Chronic Conditions– Complex Care Management
- Pregnancy

The Care Management programs consist of a multi-faceted approach including telephonic, and texting, and face to face outreach that includes various assessment and applicable interventions. The Care Management staff outreach to the Enrollee, and/or Enrollee representative, as indicated, and may collaborate with the PCP and/or Specialist to develop a plan of care.

Complex Care Management

Enrollees identified as high-risk receive targeted education on their disease(s) as well as engagement into our Complex Care Management program. Care managers and Enrollees set goals and develop a plan of care with input from the physician(s), as indicated. Enrollees are identified for the program through multiple sources, including Provider referrals and referrals from internal and external sources, and data. The Complex Care Management program is a holistic approach and evaluates Enrollee's physical, behavioral and health-related social needs. The program integrates physical health and behavioral health, and psychosocial/environmental aspects of the Enrollee's care into a single plan of care. Enrollees in the program are continually reassessed and needs evaluated to ensure optimal health outcomes.

For more information and/ or to refer Enrollees to the program call 1-844-377-2447.

Care Coordination

The Care Coordination program coordinates services for Enrollees with short-term and/or emerging risks. Care Managers support Enrollees in the resolution of pharmacy, Durable Medical Equipment (DME), discharge and transitional planning needs, dental access issues, referrals and access to physical, behavioral healthcare Providers, specialists, and community resources. Care Managers perform assessments and address needs through an individualized plan of care, providing ongoing education to Enrollees in an effort to avoid long-term complications associated with healthcare needs.

For more information and/ or to refer Enrollees to the program call 1-844-377-2447.

Enhanced Member Supports Unit (EMSU)

The Enhanced Member Supports Unit (EMSU) provides support to Enrollees for resolution of pharmacy, DME and/or dental access issues, identification of and access to Specialists, or referral and coordination with physical and/or behavioral health Providers or other community resources.

For more information and/ or to refer Enrollees call: 1-844-377-2447.

The Bright Start® Maternity Program for Pregnant Enrollees

The Bright Start Maternity Program is a focused collaboration designed to improve prenatal care for pregnant Enrollees. The Bright Start Maternity Program assesses, plans, implements, teaches, coordinates, monitors, and evaluates options and services required to meet the individual's health needs. Various modes of communication and available resources are utilized to promote quality and cost-effective outcomes. The design of the Bright Start Maternity Program allows for collaboration between the Bright Start team, the Enrollee, and the Obstetrician, for assessment and interventions to support management of medical, behavioral, and social health issues.

The Bright Start Maternity Program is designed to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program provides focused, collaborative services designed to improve prenatal care for pregnant Enrollees.

Program Goals:

- Early identification of pregnant Enrollees
- Improve health outcomes for neonates
- Facilitate access to needed services and resources
- Encourage early prenatal care and continuum of care through post-partum period by increasing awareness through Enrollee education and community alliances
- Assess and address healthcare disparities in pregnant women

Enrollees enrolled in the Bright Start Maternity Program receive a comprehensive assessment of their needs and health-related social needs (HRSN) by clinical and non-clinical staff. Based on their identified risk level, they are provided with tailored interventions, including resources, education, and ongoing follow-up to support attendance at prenatal and postpartum appointments and ensure their needs are met throughout the pregnancy journey.
To refer Enrollees to the Bright Start Maternity Program call 1-800-521-6867.

Postpartum Home Visit Program

The postpartum home visit includes a physical, psychosocial, and environmental assessment with individualized education, counseling and support. Included is at least one (1) visit provided

at their home when the Keystone First - CHIP member is released prior to 48 hours of inpatient care following a vaginal delivery or 96 hours following a Cesarean delivery, or in the case of a newborn, in consultation with the mother or the newborn's representative.
Network Providers should contact their facility's Discharge Planner to request a postpartum home visit for their patient.

Outreach & Health Education Programs

Keystone First – CHIP develops innovative programming in an effort to increase Enrollee health screening compliance in the community setting while also providing disease management/prevention education. The goal of Keystone First – CHIP's Community Health Education Programs is to increase Enrollees' knowledge of self-management skills for selected disease conditions. The health education programs focus on prevention in order to help Enrollees improve their quality of life. The Public Affairs and Marketing team targets Keystone First – CHIP Enrollees who are non-compliant for HEDIS measures, in an effort to facilitate health screenings, provide education, close care gaps, and re-connect them with their PCP's. The Keystone First – CHIP Public Affairs & Marketing team works in collaboration with the Rapid Response Outreach Team and Care Management units to achieve these desired outcomes.

Care Coordination Roles and Responsibilities

Strong care coordination depends on clear communication and shared understanding between our organization and our provider partners. To support collaborative care management and reduce duplication, gaps in care, and Enrollee confusion, we maintain a standardized process for defining and communicating care coordination roles and responsibilities.

What This Means for Providers

As a valued partner, providers play a key role in coordinated care delivery. Under this approach, providers are expected to:

- Deliver services within their scope of licensure and contractual requirements.
- Participate in care coordination activities as outlined in partner communications.
- Communicate changes in member status, service delivery issues, or coordination needs in a timely manner.

Our Role as Your Partner

Keystone First – CHIP is responsible for establishing care coordination policies and procedures, defining internal roles related to care planning and oversight, and ensuring expectations are clearly communicated through formal partner materials such as contracts, agreements, or provider communication materials.

Shared Commitment to Enrollees

Care coordination is a shared responsibility. Together, Keystone First – CHIP and the provider community work to ensure continuity of care, reduce service duplication, and support timely information exchange in accordance with applicable laws and agreements. This collaborative approach helps ensure Enrollees receive seamless, well-coordinated care.

Ongoing Communication

Roles and responsibilities between Keystone First – CHIP and providers are reviewed periodically and updated as care coordination practices or partner relationships evolve. Providers will continue to receive formal communications when updates occur to ensure clarity and alignment.

Rapid Response and Outreach Team (RROT)

The Rapid Response Team was created to address the urgent non-clinical needs of our Enrollees.

The RROT is trained to assist in the rapid triage of the Enrollee's needs. Their goal is to reduce both unnecessary emergency room visits and in-patient stays as well as assist in removing barriers to needed health care services.

The team consists of care connectors (non-clinical) who are trained to triage and assist Enrollees in overcoming barriers in achieving their health care goals. The RROT can assist Enrollees:

- Schedule doctor appointments.
- Help Enrollees with health-related social needs situations.
- Help remove barriers to health care services.
- Answer questions about how to get medicine, supplies and medical equipment.
- Find resources in the community (dental, vision, behavioral health, housing, food and clothing).
- Call Enrollees after a stay in the hospital to make sure the services they need (such as therapy and home health care) have been set up.

There are four key service functions performed:

1. **Inbound Call Service.** Enrollees and Keystone First – CHIP Providers may request RROT support via a direct, toll-free Rapid Response line at **1-844-377-2447**. Referrals to RROT are also received through many sources, such as Enrollee Services, Pharmacy, Utilization Management and Provider Relations.

2. **Outreach Service.** Outreach activities include telephonic survey or assessment completion and support of special projects or Quality initiatives. RROT associates also place outreach follow-up calls to those Enrollees who have called the 24 hour Nurse Line, ER discharges, missing gaps in care, assistance needed with health-related social needs domains and require further assistance from Care Management staff.

3. **Clinical and Non-Clinical Care Management Support.** Care Coordinators support Care Managers in Care Coordination by providing administrative support to Enrollees. These include appointment scheduling and reminders, transportation support, Enrollee educational mailings, and other administrative tasks assigned by Care Managers.

The Let Us Know program is administered through RROT and is a partnership between Keystone First – CHIP and the Provider community. This program was designed to assist Providers in the engagement and management of chronically ill Enrollees. The program supports Providers in the identification, outreach and education of Enrollees for such issues as inappropriate use of emergency room, not showing up for appointments, non-compliance with prescribed medications, assistance needed with health-related social needs domains and much more.

There are two ways to alert the Let Us Know Program:

1. Contact the Rapid Response and Outreach Team: Call **1-844-377-2447** from 8:00 a.m. until 6:30 p.m. or fax an Enrollee intervention request form to **1-833-762-7708**. The form can be found on the Let Us Know section of the Provider Center at **www.keystonefirstchip.com**
2. Refer a patient to Care Management at **1-844-377-2447**.

Domestic Violence Intervention

Keystone First – CHIP is participating in a collaborative domestic violence education program with the Department of Human Services (DHS) and other Managed Care Organizations. There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health Care Providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables Health Care Providers to assist their patients, and family Enrollees who are victims.

The clinical model known as RADAR was developed by the Massachusetts Medical Society to assist clinicians in addressing domestic violence and is an excellent tool for assisting Health Care Providers in the identification of and intervention with possible domestic violence victims.

The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

Routinely screen about partner violence.

Ask directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview the patient in private at all times.

Document information about "suspected domestic violence" or "partner violence" in the patient's chart.

Assess the patient's safety. Is it safe for her to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

Review options with the patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

You can help your patients by referring them to **www.ndvh.org** or have them contact the National Domestic Violence Hotline, where all calls are free and confidential.

National Domestic Violence Hotline
1-800-799-7233 (SAFE)
1-855-812-1001 (TTY Videophone for the Deaf)
Help is available in English, Spanish and many other preferred languages.

For a list of where to get help for a patient, please see the Appendix.

Pennsylvania Coalition Against Domestic Violence
The services provided to domestic violence victims includes crisis intervention, counseling, going along to police, medical, and court appointments, and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community. **http://www.pcadv.org/**

1-800-932-4632 (in Pennsylvania)

Network Providers can help to identify and refer Enrollees who are at high risk for particular diseases and disorders to the appropriate program.

Call the Outreach & Health Education Program Staff at 1-800-521-6007:
- With questions about health education programs
- With requests for outreach services

Pennsylvania's Early Intervention System

Early Intervention Services*
While all children grow and develop in unique ways, some children experience delays in their development. Children in Pennsylvania with developmental delays benefit from a state supported collaboration among parents, service practitioners and others who work with young children needing special services. The Pennsylvania Early Intervention program provides support and services to families with children birth to age 5 with developmental delays. Early Intervention builds upon the natural learning opportunities that occur within the daily routines of a child and their family.

Early Intervention promotes a philosophy that supports:

- Services and resources for children that enhance daily opportunities for learning provided in settings where a child would be if he/she did not have a disability.
- Families' independence and competencies.
- Respect of families' strengths, values and diversity.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

*Source – **https://www.dhs.pa.gov/Services/Children/Pages/Early-Intervention-Services.aspx**

What Children Are Eligible?
Children from birth to age 5 who have Special Healthcare Needs due to developmental delays or disabilities are eligible to receive Early Intervention services.

Following a Bright Futures screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through CONNECT Helpline at **1-800-692-7288** and document the referral in the child's medical record.

What Services are Provided to Meet the Developmental Needs of a Child?
The services provided to children and their families differ based upon the individual needs and strengths of each child and the child's family. Services such as parent education, support services, developmental therapies and other family-centered services that assist in child development and may be included in a family's Early Intervention program.

Early Intervention promotes collaboration among parents, service Providers and other important people in the child's life to enhance the child's development and support the needs of the family.

Where do Children and Their Families Receive Services?
Services may be provided in the child's home, child care center, nursery school, play group, Head Start program, early childhood special education classroom or other settings familiar to the family. Early Intervention provides supports and services in a variety of settings at no cost to the family. Early Intervention supports and services are embedded in typical routines and activities, within the family, community and/or early care and education settings. This approach provides frequent, meaningful practice and skill building opportunities.

Parents who have questions about their child's development may contact the **CONNECT Helpline at 1-800-692-7288**. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children ages birth to age 5. In addition, CONNECT can assist parents by making a direct link to their local Early Intervention program or local preschool Early Intervention program.

Referrals to Early Intervention are directed to the local Early Intervention service coordination unit. Initial contact with the referred family occurs locally and at a time and place convenient to the family.

Specialists as PCPs for Enrollees with Special Healthcare Needs

Specialists may be able to serve as PCPs for Enrollees with Special Healthcare Needs**,** including Enrollees that have a disease or condition that is life threatening, degenerative, or disabling. Keystone First – CHIP Enrollees may contact the Enhanced Member Support Unit to request designation as an Enrollee "Special Healthcare Needs" and request approval to utilize a specialist as PCP. Care Managers will work with the Enrollee and Keystone First – CHIP staff to identify an appropriate Specialist. The Specialist must have expertise in the treatment of the medical condition of the Enrollee.

To accommodate these Enrollees, Keystone First – CHIP's Enhanced Member Support Unit will contact the requested Specialist and obtain their verbal agreement to provide specialty care services, as well as, primary care services. The Specialist will be informed that the final approval is subject to meeting credentialing requirements and office accessibility standards. Upon approval, this information will be forwarded to the Provider Network Management and Enrollee Services Departments. Keystone First – CHIP's Provider Network Management Department will negotiate a contract with specialists who meet Keystone First – CHIP's Credentialing criteria, and who wish to function as a PCP for an Enrollee(s) with Special Healthcare Needs. The specialist will be set-up in our Provider Network database as a "Specialist as PCP". The Enrollee will then be assigned to the "Specialist as PCP" panel.

Section X
Enrollee Rights and Responsibilities

Enrollee Rights & Responsibilities

Keystone First – CHIP and its network of Providers do not discriminate against Enrollees based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law. Keystone First – CHIP Enrollees have the following rights and responsibilities. Providers can obtain Enrollee Rights and Responsibilities on the Enrollee page of our website at **www.keystonefirstchip.com**.

Enrollee Rights

Enrollees have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by **Keystone First – CHIP** staff and network Providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about **Keystone First – CHIP**, its services, and the doctors and other Providers that treat them.
- To pick the network health care Providers that they want to treat them.
- To get emergency services when they need them from any Provider without **Keystone First – CHIP's** approval.
- To get information that they can easily understand and talk to their Providers about their treatment options, risks of treatment, and tests that may be self-administered without any interference from **Keystone First – CHIP**.
- To make all decisions about their health care, including the right to refuse treatment. If they cannot make treatment decisions by themselves, they have the right to have someone else help them make decisions or make decisions for them.
- To talk with Providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to their records.
- To ask for a second opinion.
- To file a Grievance if they disagree with **Keystone First – CHIP's** decision that a service is not medically necessary for them.
- To file a Complaint if they are unhappy about the care or treatment they have received.
- To ask for a Department of Human Services (DHS) Fair Hearing regarding an eligibility determination
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the Provider, or to punish them.
- To get information about services that **Keystone First – CHIP** or a Provider does not cover because of moral or religious objections and about how to get those services.

- To exercise their rights without it negatively affecting the way DHS, **Keystone First – CHIP**, and network Providers treat them.
- To create an advance directive. Enrollees can see their Enrollee Handbook for more information.
- To make recommendations about the rights and responsibilities of **Keystone First – CHIP's** Enrollees.
- To know and get information about:
    - **Keystone First – CHIP** and its health care Providers.
    - Their Enrollee rights and responsibilities.
    - Their benefits and services.
    - The cost of health care.
- To talk with their health care Provider about:
    - Their treatment plans, regardless of cost or benefit coverage.
    - The kinds of care they can choose to meet their medical needs, in a way they understand.
- To take an active part in the decisions about their health care, including the right to refuse treatment. Their decision to do so will not negatively affect the way they are treated by **Keystone First – CHIP**, its health care Providers, or DHS.
- To voice complaints about and/or appeal decisions made by **Keystone First – CHIP** and its health care Providers.
- To be given an opportunity to make suggestions for changes in **Keystone First – CHIP** policies and procedures.

Enrollee Responsibilities

Enrollees need to work with their health care service Providers. **Keystone First – CHIP** needs Enrollees' help so that they get the services and supports they need.

These are the things Enrollees should do:

- Provide, to the extent they can, information needed by their Providers.
- Follow instructions and guidelines given by their Providers.
- Be involved in decisions about their health care and treatment.
- Work with their Providers to create and carry out their treatment plans.
- Tell their Providers what they want and need.
- Learn about **Keystone First – CHIP** coverage, including all covered and non-covered benefits and limits.
- Use only network Providers unless **Keystone First – CHIP** approves an out-of-network Provider or they have Medicare.
- Get a referral from their primary care Provider (PCP) to see a specialist.
- Respect other patients, Provider staff, and Provider workers.
- Make a good-faith effort to pay their co-payments.

- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.
- Let **Keystone First – CHIP** and their health care Providers know of any changes that may affect their membership, health care needs, or benefits. Some examples include, but are not limited to, the following:
    - They are pregnant.
    - They have a new baby.
    - Their address or phone number changes.
    - They or 1 of their children have other health insurance.
    - They have a special medical condition.
    - They change their PCP.
    - Their family size changes.
    - They move out of the county or state that they live in now.
- Work with **Keystone First – CHIP** and our health care Providers. This means they should follow the guidelines given to them about **Keystone First – CHIP** and they should follow their health care Provider's instructions about their care. This includes:
    - Making appointments with their health care Provider.
    - Canceling appointments when they cannot make their appointments.
    - Calling **Keystone First – CHIP** when they have questions.
- Talk with their health care Provider to agree on goals for their treatment, to the degree they are able to do so.
- Talk with their health care Provider so they can understand their health problems, to the degree they are able to do so.

Enrollees have the responsibility to treat their Network Provider and the Network Provider's staff with respect and dignity.

Patient Self-Determination Act

The Patient Self-Determination Act is a Federal law recognized in the Commonwealth of Pennsylvania. It states that competent adults have the right to choose medical care and treatment. An Enrollee has the right to make these wishes known to his/her PCP and other Providers as to whether he/she would accept, reject or discontinue care under certain circumstances.

An Enrollee should prepare an advance directive to maintain his/her rights in a situation where he/she may not be able to tell his/her Health Care Provider what is/is not wanted. Once the Enrollee has prepared an advance directive, a copy should be given to his/her PCP. The Health Care Provider should be aware of and maintain in the Enrollee's medical record a copy of the Enrollee's completed advance directive. Enrollees are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive.

An **Advance Directive** is only used when the Enrollee is not able to make decisions about his/her treatment, such as if the Enrollee is in a coma.

There are two kinds of documents that can act as an advance directive in the Commonwealth of Pennsylvania:

Living Will

A living will is a written record of how a competent adult Enrollee wishes his/her life to be sustained in the event he/she is unable to communicate with a Health Care Provider. This document should outline the type of treatments the Enrollee would or would not want to receive.

Durable Health Care Power of Attorney

This legal document names the person the Enrollee assigns to make medical treatment decisions for him/her in case he/she cannot make them for himself/herself. This person does not have to be an attorney.

If Enrollees or their parent or guardian have questions about the Patient Self-Determination Act and Advance Directives, refer them to Enrollee Services at **1-844-472-2447** for assistance.

Section XI
Regulatory Provisions

Access to & Financial Responsibility for Services

Enrollee's Financial Responsibilities

Providers may bill an Enrollee if:

- If the Enrollee did not pay their co-payment.
- The Enrollee received services from an out-of-network Provider without approval from the Plan and the Provider told the Enrollee before services were received that the service would not be covered, and the Enrollee agreed to pay for the service.
- The Enrollee received services that are not covered by the Plan, the Provider told the Enrollee before they received the service that the service would not be covered, and Enrollee agreed to pay for the service.
- The Enrollee received a service from a Provider who is not enrolled with the Commonwealth.
- The Enrollee goes over a benefit limit on a service.
- The Enrollee receives a medical service that is not a covered benefit.

Services Provided by a Non-Participating Provider

Keystone First – CHIP's Provider Services Department will make every effort to arrange for the Enrollee to receive all necessary medical services within Keystone First – CHIP's Network of Providers in collaboration with the recommendations of the PCP. Occasionally, an Enrollee's health care needs cannot be met through the Keystone First – CHIP Network of Providers. All services by Non-Participating Providers (except Emergency Services, Family Planning Services through Keystone First – CHIP, and Medicare covered services by a Medicare Health Care Provider) require Prior Authorization from the Keystone First – CHIP Utilization Management Department. Unauthorized services rendered by Non-Participating Providers are not compensable and may become the financial responsibility of the Keystone First – CHIP Enrollee if the Enrollee chooses to receive services or treatment by the Non-Participating Provider.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of Providers (Code of Federal Regulations: 42CFR, §455.410), all Providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This does not apply to non-participating out-of-state Providers under single case agreements.

DHS may make a determination that adopts encounter limits or thresholds that would require the non-participating out-of-state Providers to convert to in-network status, which would require enrollment in the Pennsylvania Medical Assistance Program.

Additionally, all Providers, including those who order, refer or prescribe items or services for Keystone First – CHIP Enrollees, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed at **www.pa.gov/agencies/dhs → Resources & Information → For Providers → Bulletin Search** or on the Keystone First - CHIP Provider Center at **www.keystonefirstchip.com → Providers → Resources → Communications → Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletins.**

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider. Enroll by visiting: **https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx**

Services Provided Without Required Referral/Authorization

Except for certain services, and Network Providers for which specific prepayment arrangements have been made, e.g., lab services and certain PCP services, Keystone First – CHIP requires Prior Authorization of certain health care treatment and services rendered to its Enrollees. Health Care Providers should refer to Section II of the Manual titled "Referral and Authorization Requirements" for this information. Enrollees should also be referred to the Enrollee Handbook for a listing of those services that require a referral or Prior Authorization. Keystone First – CHIP is not obligated to provide reimbursement for services that have not been appropriately authorized.

Enrollee Accessibility to Providers for Emergency Care

No Prior Authorization for Emergency Services

Keystone First – CHIP does not require Prior Authorization or pre-approval of any Emergency Services.

Keystone First – CHIP PCP and Specialist Office Standards (see Section VI of this Manual) require Network Providers to provide Medically Necessary covered services to Keystone First – CHIP Enrollees, including emergency and/or consultative specialty care services, 24 hours a day, 7 days a week. Enrollees may contact their PCP for initial assessment of medical emergencies.

In cases where Emergency Services are needed, Enrollees are advised to go to the nearest Hospital Emergency Room (ER), where ER staff should immediately screen all Keystone First – CHIP Enrollees and provide appropriate stabilization and/or treatment services.

Care Out of Service Area

Keystone First – CHIP Enrollees have access to Emergency Services when traveling anywhere in the United States. Although not required, Enrollees are encouraged to contact their PCP to report any out-of-area Emergency Services received.

Keystone First – CHIP is required to comply with requirements outlined by the Affordable Care Act (ACA) §42 CFR 455 and the Pennsylvania Department of Human Services (DHS) that all Providers, including those who order, refer or prescribe items or services for Keystone First – CHIP Enrollees, must be enrolled in the Pennsylvania Medical Assistance (MA) Program. The complete DHS MA bulletin (99-17-02) outlining all requirements can be accessed by **visiting www.pa.gov/agencies/dhs → Resources & Information → For Providers → Bulletin Search** or on the Keystone First - CHIP Provider Center at **www.keystonefirstchip.com → Providers → Resources → Communications → Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletins.**

Keystone First – CHIP will use the NPI of the ordering, referring or prescribing Provider included on the rendering Provider's claim to validate the Provider's enrollment in the Pennsylvania MA program. A claim submitted by the rendering Provider will be denied if it is submitted without the ordering/prescribing/referring Provider's Pennsylvania MA enrolled Provider's NPI, or if the NPI does not match that of a Pennsylvania enrolled MA Provider.

Important Note: Keystone First – CHIP is prohibited from making payment for items or services to any financial institution or entity located outside of the United States or its territories

Compliance with HIPAA Privacy Regulations

As a covered entity, Keystone First – CHIP is required to comply with the privacy standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Keystone First – CHIP complies with the provisions of the HIPAA privacy regulations, including, but not limited to, the following:

- Designation of a Privacy Officer who is responsible for oversight of the on-going activities related to the Keystone First – CHIP's privacy programs and privacy practices designed to safeguard Enrollee's protected health information (PHI)
- Development of a centralized Privacy Office, which is responsible for the day-to-day activities related to Keystone First – CHIP's privacy program and support of privacy-related initiatives conducted by Keystone First – CHIP
- Providing copies of Keystone First – CHIP's Notice of Privacy Practices to newly enrolled and existing Enrolles of the health plan, which describes how medical information is used and disclosed, as well as how it can be accessed
- Establishing processes for our Enrollees to exercise their rights provided for under HIPAA, such as requesting access to their PHI, or complaining about Keystone First – CHIP's privacy practices

Allowed Activities Under the HIPAA Privacy Regulations

HIPAA allows covered entities, including health care providers and health plans (such as Keystone First – CHIP), the ability to use or disclose PHI about its Enrollees for the purposes of Treatment, Payment and/or Health Care Operations (TPO) without an Enrollee's consent or authorization. This includes access to an Enrollee's medical records when necessary and appropriate.

"TPO" allows a health care provider and/or Keystone First – CHIP to share Enrollees' PHI without consent or authorization with other covered entities if both covered entities have or had a relationship with the Enrollee. A covered entity may also use and disclose protected health information for its own treatment, payment, and health care operations activities.:

"Treatment" includes the provision, coordination and management of healthcare including consultation between providers and referral of an Enrollee from one provider to another.

"**Payment**" includes activities of a health plan to furnish or obtain reimbursement for health care services provided to an Enrollee and the activities of a provider to obtain reimbursement for service provided to an Enrollee. These activities may include, but are not limited to:

- Determination of Enrollee eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of health care providers for payment or reimbursement to fulfill Keystone First – CHIP's coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to Enrollees

"Health Care Operations" includes the following activities:

- Quality assessment and improvement activities such as Care Management and care coordination
- Quality of care reviews in response to Enrollee or state/federal queries
- Response to Enrollee Complaints/Grievances
- Site visits as part of credentialing and recredentialing
- Administrative and financial operations such as conducting Health Plan Employer Data And Information Set (HEDIS) reviews
- Enrollee services activities
- Legal activities such as audit programs, including Fraud and abuse detection to assess conformance with compliance programs
- Business planning and development

While there are other purposes under HIPAA for which Keystone First – CHIP and/or a health care provider might need to use or disclose an Enrollee's PHI, TPO covers a broad range of information sharing.

Contact Information

Listed below are general contact addresses for accessing Keystone First – CHIP, DHS, and other related organizations. For information about additional organizations, contact Provider Services at **1-800-521-6007** or Enrollee Services at **1-844-472-2447**.

Keystone First – CHIP
200 Stevens Drive
Philadelphia, PA 19113

Department of Human Services
Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, PA 17105

Office of Maternal & Child Health
1101 Market Street
9th Floor
Philadelphia, PA 19107
1-215-685-5225
1-215-685-5257 (fax)

Cultural Responsiveness

Cultural Responsiveness, as defined by the Pennsylvania Department of Human Services (DHS), is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

In addition, DHS Office of Minority Health defines Cultural Humility as a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them.

Further, Section 601 of Title VI of the Civil Rights Act of 1964 states that:
No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In addition, Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health care based on race, color, national origin, sex (includes gender identity and sexual orientation), age, disability in health programs and activities receiving federal funds.

Discriminatory actions against those of Limited English Proficiency (LEP), Low Literacy Proficiency (LLP) or sensory impairment can be seen as discrimination on the basis of national origin. Therefore, these Medical Assistance recipients must be allotted equal access to all services and benefits of Keystone First – CHIP.

Recipients of federal financial assistance would include the Pennsylvania Medical Assistance Program, and by extension, Medical Assistance Managed Care Organizations, i.e., Keystone First – CHIP and its Network Providers.

As a participant in the Pennsylvania Medical Assistance program, all practitioners and other health care Providers must take reasonable steps to provide meaningful access to language service assistance as defined by this section of the Civil Rights Act of 1964. Language services include verbal interpreter services and written translation services in Enrollee's preferred language or formats.

In order to be in compliance with federal law and state contractual requirements, Keystone First – CHIP and its Network Providers have an obligation to provide language services to LEP and LLP Enrollees and to make reasonable efforts to accommodate Enrollees with other sensory impairments.

If a Keystone First – CHIP Enrollee requires or requests translation services because they are either non-English speaking, or of LEP, or of LLP, or if the Enrollee has some other sensory impairment, the Health Care Provider has a responsibility to make arrangements to procure translation services for those Enrollees, and to facilitate the provision of health care services to such Enrollees.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as Health Care Providers) must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/ Health Care Provider relationship.

Providers are required to:

- Provide written and oral language assistance at no cost to Plan Enrollees with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of competent language interpreters, upon request*.
- Advise Enrollees that translation services are available through Keystone First – CHIP if the Provider is not able to procure necessary translations services for an Enrollee.

- **Make available auxiliary aids and services, such as alternative formats and sign language interpreters, free of charge, when necessary for effective communication.**
- Provide Enrollees verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.
- Post and offer easy-to-read Enrollee signage and materials in the languages of the common ethnic groups in the Provider's service area. **Post statements that language services are available in the top 15 non-English languages spoken in Pennsylvania***
- Vital documents, such as patient information forms and treatment consent forms, must be made available in Enrollee's preferred language and formats.
- **Use top 15-language taglines in large-sized communications, such as outreach publication or written notices.***
- Discourage Enrollees from using family or friends as oral translators.
- **Display notice of individual's rights that includes information about LEP communication help.**

***As determined by DHS, the top 15 written non-English languages in Pennsylvania are:**

Spanish	**Russian**	**Ukrainian**
Chinese (simplified/Mandarin)	**Portuguese (Brazil)**	**Korean**
Arabic	**Cambodian (Khmer)**	**Gujarati**
Nepali	**Bengali**	
Vietnamese	**French**	
Haitian Creole	**Chinese (Cantonese)**	

For complete details, guidelines and the Taglines Representing the Top Fifteen (15) Non-English Languages in Pennsylvania attachment, refer to PA DHS MA Bulletin 99-25-01.
To access DHS Medical Assistance Bulletins (MABs) **visit www.pa.gov/agencies/dhs → Resources & Information → For Providers → Bulletin Search** or on the Keystone First - CHIP Provider Center at **www.keystonefirstchip.com → Providers → Resources → Communications → Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletins.**
. The tagline attachment is also available on the Cultural Competency section on the Provider Center.

Note: The assistance of friends, family, and bilingual staff is **not** considered competent, quality interpretation. These persons should not be used for interpretation services except where an Enrollee has been made aware of his/her right to receive free interpretation and continues to insist on using a friend, family Enrollee, or bilingual staff for assistance in his/her preferred language.

*Keystone First – CHIP contracts with a competent telephonic interpreter service Provider. We have an arrangement to make our corporate rate available to participating Network Providers.

For information on using the telephonic interpreter service, visit the Cultural Responsiveness page on www.keystonefirstchip.com or contact Provider Services at **1-800-521-6007**.

Additionally under the Culturally Linguistically Appropriate Standards (CLAS) of the Office of Minority Health, Plan Providers are strongly encouraged to:

- Provide effective, understandable, and respectful care to all Enrollees in a manner compatible with the Enrollee's cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for Plan Enrollees upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all Enrollee medical records.

Keystone First – CHIP has a Cultural Responsiveness Plan. Providers may request a copy by contacting Provider Services at **1-800-521-6007**.

Keystone First – CHIP's Corporate Confidentiality Policy

The policy states that during the course of business operations, Confidential Information and/or Proprietary Information, including Enrollee Protected Health Information (PHI), may become available to Keystone First – CHIP Associates, Consultants and Contractors. Keystone First – CHIP's use and disclosure of Enrollee PHI is regulated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. Keystone First – CHIP's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the confidentiality and disclosure of health information.

Keystone First – CHIP is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of Enrollee PHI, in compliance with all applicable laws and regulations. It is the obligation of all Keystone First – CHIP Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of Keystone First – CHIP's Confidentiality Policy and other Keystone First – CHIP policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, will be handled on a need-to-know basis. The Keystone First – CHIP Confidentiality Policy and other Keystone First – CHIP policies and procedures are adopted to protect the confidentiality of such information consistent with the need to effectively conduct business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality

through the use of aggregated data wherever possible. No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to Keystone First – CHIP or an Enrollee to any other Associate, Consultant or Contractor unless such a disclosure is consistent with the Keystone First – CHIP Confidentiality Policy.

Both during and after an Associate's association with the Keystone First – CHIP, it shall be a violation of the Keystone First – CHIP Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with Keystone First – CHIP or as otherwise required by law. It is also a violation of Keystone First – CHIP's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of Keystone First – CHIP. To the extent that a violation of the Keystone First – CHIP Confidentiality Policy occurs, Keystone First – CHIP reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the Keystone First – CHIP Confidentiality Policy will subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within Keystone First – CHIP.

Confidential information and proprietary information includes, but is not limited to the following:

- Protected Health Information
- Medical or personal information pertaining to Associates of Keystone First – CHIP ("the Company") and/or its Customers
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, Enrollees, and/or Customers
- Information that Keystone First – CHIP is required by law, regulation, agreement or policy to maintain as confidential
- Financial information regarding the Company, its Enrollees, Network Providers and Customers, including but not limited to contract rates and fees
- Associate personnel and payroll records
- Information, ideas, or data developed or obtained by Keystone First – CHIP, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, Health Care Provider payment rates, business of Keystone First – CHIP and/or its Customers
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of Keystone First – CHIP and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs
- Information concerning Keystone First – CHIP 's business plans
- Information that could help others commit Fraud or sabotage or misuse Keystone First – CHIP 's products or services

Procedure

1. Associates, Consultants and Contractors may use Confidential or Proprietary Information and may disclose Confidential or Proprietary Information internally within Keystone First – CHIP only as necessary to fulfill the responsibilities of their respective position.
2. Confidential Information which is specific to an Associate or Health Care Provider may not be released by Keystone First – CHIP to another party, except as permitted or required by law or regulation, without first obtaining the written consent of that individual. PHI may not be disclosed, other than as permitted or required by law or regulation, or for purposes of treatment, payment or health care operations, without first obtaining a written Authorization as required by HIPAA, or other form of consent as may be required by state law. If an individual is unable to make his/her own decision regarding consent, a legal guardian or other legally authorized representative must provide written consent or an Authorization on the individual's behalf.
3. Associates, Consultants or Contractors, may not disclose Confidential or Proprietary Information to persons or organizations outside Keystone First – CHIP, unless otherwise required by law or regulation or approved by the Legal Affairs Department. Associates, Consultants or Contractors may not make any direct or indirect communication of any kind with the press or any other media about the business of Keystone First – CHIP without express written approval from the Communications Department.
4. Information that pertains to Keystone First – CHIP 's operations may be disclosed to Keystone First – CHIP's general partners, Independence Blue Cross and Blue Cross Blue Shield of Michigan, d/b/a Keystone First – CHIP, on a need to know basis; provided, however, that Confidential Information and Proprietary Information belonging or pertaining to a Customer may be disclosed ONLY to representatives of that Customer.
5. Any Associate, Consultant or Contractor who is approached with an offer of Confidential Information including PHI or Proprietary Information to which he/she should not have access and/or which was improperly obtained must immediately discuss the matter with his/her supervisor, an attorney in the Legal Affairs Department, the Chief Compliance Officer or the Internal Auditor.
6. All Associates, Consultants and Contractors must review and familiarize themselves with all departmental or any other Keystone First – CHIP policies and procedures applicable to confidentiality issues arising within the course of performing their job duties.
7. Each Associate's, Consultant's, and Contractor's level of access to the information maintained in Keystone First – CHIP 's computer system is determined by the Information Services Department, based upon the individual's department and job duties. Associates are to access and distribute data electronically only in accordance with instructions given by the Information Services or the Corporate Compliance departments. All Associates, Consultants and Contractors are required to comply with the Information Services policies and procedures regarding security and access to data, electronic mail and other information systems.
8. Associates, Consultants and Contractors must also follow reasonable confidentiality restrictions imposed by previous employers and not use or share that employer's confidential information with Keystone First – CHIP.

9. All Consultants/Contractors, including those who are Enrollees of Keystone First – CHIP committees, will sign a confidentiality and non-disclosure agreement for the protection of Confidential Information and Proprietary Information.
10. All agreements with Network Providers, Consultants and Contractors will include confidentiality provisions that are consistent with this Policy and Procedure and that require, at a minimum, that the Provider/Subcontractor comply with all federal and state statutes and regulations regarding the disclosure of Confidential Information and otherwise maintain Keystone First – CHIP's Confidential Information and Proprietary Information as confidential. The material elements of this policy and procedure will be communicated to participating Network Providers via Keystone First – CHIP's Network Provider agreements and Network Provider manuals. To the extent that a Health Care Provider, Consultant or Contractor is a Business Associate pursuant to HIPAA, such Health Care Provider, Consultant or Contractor must execute a Business Associate agreement governing the Business Associate's use and disclosure of Protected Health Information as required by HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act.
11. The Legal Affairs and/or Corporate Compliance Department should be contacted whenever issues of confidentiality and/or disclosure of Confidential Information or Proprietary Information arise which are not clearly addressed in the Keystone First – CHIP Confidentiality Policy or other Keystone First – CHIP policies and procedures.
12. The Director of Privacy or designee will report to the Compliance and Privacy Committee, all Enrollee, Health Care Provider and Associate complaints regarding confidentiality as well as the resolution of such complaints. The Compliance and Privacy Committee will determine if operational practices should be altered to prevent or reduce the risk of future concerns.

Provider Protections

Keystone First – CHIP shall not exclude, discriminate against or penalize any Health Care Provider for its refusal to allow, perform, participate in or refer for health care services, when the refusal of the Health Care Provider is based on moral or religious grounds. The Health Care Provider must make information available to Enrollees, prospective Enrollees and Keystone First – CHIP about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to Keystone First – CHIP Enrollees, due to religious or moral grounds.

Health Care Providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. Keystone First – CHIP will not engage in or condone any such discriminatory practices.

Keystone First – CHIP shall not discriminate against or exclude from Keystone First – CHIP's Provider Network any Health Care Provider because the Health Care Provider advocated on behalf of an Enrollee in a Utilization Management appeal or another dispute with Keystone First – CHIP over appropriate medical care, or because the Health Care Provider filed an appeal on behalf of a Keystone First – CHIP Enrollee.

Keystone First – CHIP does not have policies that restrict or prohibit open discussion between Health Care Providers and Keystone First – CHIP Enrollees regarding treatment options and alternatives. Keystone First – CHIP encourages open communication between Health Care Providers and our Enrollees with regard to all treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

Section XII
Appendix

Exclusions — What is Not Covered

The following list was taken from the Keystone First – CHIP Enrollee handbook.

1. Services or supplies that are:
    - Not provided by or referred by your child's primary care physician except in an emergency or as specified elsewhere in this Benefits Handbook
    - Not medically necessary, as determined by your child's primary care physician or referred specialist or Keystone First - CHIP, for the diagnosis or treatment of illness, injury, or restoration of physiological functions; this exclusion does not apply to routine and preventive covered services specifically provided under this contract and described in this Benefits Handbook
    - Provided by family members, relatives, and friends
2. Services for any occupational illness or bodily injury that occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of workers' compensation law or any similar occupational disease law or act; this exclusion applies whether or not the Enrollee claims the benefits or compensation
3. Services, charges, or supplies for which an Enrollee would have no legal obligation to pay, or another party has primary responsibility
4. For any loss sustained or expenses incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared
5. Care related to military service disabilities and conditions that your child is legally entitled to receive at government facilities which are not Keystone First - CHIP providers, and which are reasonably accessible to your child
6. Any charges for services, supplies, or treatment while an Enrollee is incarcerated in any adult or juvenile penal or correctional facility of institution
7. Care for conditions that federal, state, or local law requires to be treated in a public facility
8. Services, supplies, or charges paid or payable by Medicare when Medicare is primary (for purposes of this Benefits Handbook, a service, supply, or charge is "payable under Medicare" when the Enrollee is eligible to enroll for Medicare benefits, regardless of whether the Enrollee actually enrolls for, pays applicable premiums for, maintains, claims, or receives Medicare benefits)
9. For injuries resulting from the maintenance or use of a motor vehicle if the treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law
10. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a prescribed plan of treatment
11. Services or supplies that are experimental/investigative in nature, except Routine Patient Costs Associated With Qualifying Clinical Trials that meet the definition of a Qualifying

Clinical Trial under this Benefits Handbook, and which have been preapproved by Keystone First - CHIP
Routine patient costs do not include any of the following:

- The investigational item, device, or service itself
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

12. Routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for camp, college or travel, and examinations for insurance, licensing, and employment
13. For care in a long-term care facility, including a nursing home; home for the aged; convalescent home, school, camp, or institution for intellectually disabled children; or custodial care in a skilled nursing facility
14. Cosmetic surgery, including cosmetic dental surgery — defined as any surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected
    - This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation, or change in appearance of a portion of the body, including but not limited to the ears, lips, chin, jaw, nose, or breasts, except reconstruction for post-mastectomy patients.
    - This exclusion does not include those services performed when the patient is an Enrollee of Keystone First - CHIP and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process.
    - This exclusion does not apply to otherwise covered services necessary to correct medically diagnosed congenital defects and birth abnormalities for children.
15. Any therapy service provided for:
    - Work hardening activities/programs
    - Evaluations not associated with therapy
16. All surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to, radial keratotomy and refractive keratoplasty
17. Immunizations required for employment purposes or travel
18. Custodial and domiciliary care, residential care, protective and supportive care, including educational services, rest cures, and convalescent care
19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary
    - This exclusion does not apply to Keystone First - CHIP's weight reduction program or nutrition counseling visits/sessions as provided by Keystone First - CHIP through its nutrition counseling for weight management benefit.

- This exclusion does not include weight reduction services that are required to be covered under the Affordable Care Act.

20. For Medical Foods and Nutritional Formulas:
    - Appetite suppressants
    - Oral non-elemental nutritional supplements (e.g., Boost, Ensure, NeoSure, PediaSure, Scandishake), casein hydrolyzed formulas (e.g., Nutramigen, Alimentum, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, or soy-based products; this exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the Description of Covered Services
    - Elemental semi-solid foods (e.g., Neocate Nutra)
    - Products that replace fluids and electrolytes (e.g., Electrolyte Gastro, Pedialyte)
    - Oral additives (e.g., Duocal, fiber, probiotics, or vitamins) and food thickeners (e.g., Thick-It, Resource ThickenUp)
    - Supplies associated with the oral administration of formula (e.g., bottles, nipples)
21. Personal or comfort items such as television, telephone, air conditioning, humidifiers, barber or beauty service, guest service, and similar incidental services and supplies that are not medically necessary
22. Sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist
23. Routine foot care, as defined in the carrier's medical policy, unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes
24. Marriage or religious counseling
25. In vitro fertilization, embryo transplant, ovum retrieval including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and any services required in connection with these procedures
26. Services for repairs or replacements of prosthetic devices or Durable Medical Equipment needed because the item was abused, lost, or misplaced
27. Reversal of voluntary sterilization and services required in connection with such procedures
28. Wigs and other items intended to replace hair loss due to androgenetic alopecia; or due to illness or injury including, but not limited to, injury due to traumatic or surgical scalp avulsion, burns, or chemotherapy
29. Ambulance Services/Transport, unless medically necessary, and as provided in the subsection entitled "Ambulance Services/Transport" specified in Outpatient Services of this Benefits Handbook
30. Services required by an Enrollee donor related to organ donation
    - Expenses for donors donating organs to Enrollee recipients are covered only as described in this Benefits Handbook and provided under the contract.
    - No payment will be made for human organs that are sold rather than donated.
31. Charges for completion of any insurance form

32. Foot orthotic devices except as described in this Benefits Handbook and provided under the contract. This exclusion does not apply to foot orthotic devices used for the treatment of diabetes.
33. Any services, supplies, or treatments not specifically listed in the Benefits Handbook or provided under the contract as covered benefits, unless the unlisted benefit, service, or supply is a basic health service required by the Pennsylvania Department of Health. Keystone First - CHIP reserves the right to specify providers of, or means of delivery of, covered services, supplies, or treatments under this plan, and to substitute such providers or sources where medically appropriate.
34. Prescription drugs and medications, except what is provided under the Prescriptions section described in this Benefits Handbook
35. Contraceptives, except what is covered under the Prescriptions section described in this Benefits Handbook
36. The following outpatient services that are not performed by your child's primary care physician's designated provider, when required under the plan, unless preapproved by Keystone First - CHIP:
    - Rehabilitation therapy services (other than speech therapy and services for Autism Spectrum Disorders)
    - Diagnostic radiology services for children age five (5) or older
    - Laboratory and pathology tests
37. Cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to, physical, occupational, and speech therapies in a multidisciplinary, goal-oriented, and integrated treatment program designed to improve management and Keystone First - CHIP following neurological damage to the central nervous system caused by illness or trauma (e.g., stroke, acute brain insult, encephalopathy)
38. Charges in excess of benefit maximums
39. Equipment costs related to services performed on high-cost technological equipment unless the acquisition of such equipment was approved through a Certificate of Need process and/or Keystone First – CHIP
40. Services incurred prior to the effective date of coverage
41. Services that were or are incurred after the date of termination of the Member's coverage, except as provided in this Benefits Handbook
42. Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trust, or similar person
43. Counseling with patient's relatives except as may be specifically provided in the subsection titled "Your Child's Substance Use Benefits — What is Covered" or "Transplant Services" specified in the Inpatient and Outpatient sections of this Benefits Handbook
44. With regard to Durable Medical Equipment (DME), no item is covered that:
    - Is for comfort or convenience, including, but not limited to, massage devices and equipment; portable whirlpool pumps; telephone alert systems; bed-wetting alarms; and ramps

- Is for environmental control, including, but not limited to, air cleaners; air conditioners; dehumidifiers; portable room heaters; and ambient heating and cooling equipment
- Is inappropriate for home use; an item that generally requires professional supervision for proper operation including, but not limited to, diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes
- Is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function — meaning the equipment (i) is not durable or (ii) is not a component of the DME
- Is not primarily medical in nature. Equipment that is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: exercise equipment; speech teaching machines; strollers; toileting systems; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief
- Has features of a medical nature which are not required by the patient's condition, such as a gait trainer; the therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a medically necessary and realistically feasible alternative item that serves essentially the same purpose
- Duplicates or supplements existing equipment for use when traveling or for an additional residence — for example, a patient who lives in the Northeast for six (6) months of the year, and in the Southeast for the other six (6) would not be eligible for two (2) identical items, or one (1) for each living space
- Is not customarily billed for by the provider, including, but not limited to, delivery; setup and service activities (such as routine maintenance, service, or cleaning); and installation and labor of rented or purchased equipment
- That modifies vehicles, dwellings, and other structures, including (i) any modifications made to a vehicle, dwelling, or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling, or other structure for the DME item such as a wheelchair
- Equipment for safety — items that are not primarily used for the diagnosis, care, or treatment of disease or injury but are primarily used to prevent injury or provide a safe surrounding; examples include: restraints, safety straps, safety enclosures, and car seats. We will neither replace nor repair the DME due to abuse or loss of the item.

45. With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:
    - The item is for comfort or convenience
    - The item is not primarily medical in nature including, but not limited to, earplugs, ice packs, silverware/utensils, feeding chairs, and toilet seats
    - The item has features of a medical nature which are not required by the patient's condition

- The item is generally not prescribed by an eligible provider

Some examples of not-covered consumable medical supplies are incontinence pads; lamb's wool pads; face masks (surgical); and disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations.

46. For skilled nursing facility benefits:
    - When confinement is intended solely to assist an Enrollee with the activities of daily living or to provide an institutional environment for the convenience of an Enrollee
    - For the treatment of substance use and behavioral health care
    - After the Enrollee has reached the maximum level of recovery possible for the Enrollee's particular condition and no longer requires definitive treatment other than routine custodial care
47. The cost of home blood pressure machines, except for Enrollees: a) with pregnancy-induced hypertension; b) with hypertension complicated by pregnancy; c) with end-stage renal disease receiving home dialysis; or (d) who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates
48. In regard to hospice care:
    - Research studies directed to life-lengthening methods of treatment
    - Expenses incurred in regard to the Enrollee's personal, legal, and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property)
    - Treatment to cure the Enrollee's illness
49. Alternative Therapies/Complementary Medicine, including, but not limited to: acupuncture; music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; Rolfing; psychodrama; vitamin or other dietary supplements and therapy, except as required to be covered under the Affordable Care Act; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy
50. Health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents (except as covered per Keystone First – CHIP's Drug Formulary).
51. Medical supplies such as (but not limited to) thermometers, ovulation kits, or early pregnancy or home pregnancy testing kits
52. Charges not billed/performed by a provider
53. Services performed by a professional provider enrolled in an educational or training program when such services are related to the educational or training program and are provided through a hospital or university
54. Home health care services and supplies in connection with home health services for the following:
    - Custodial services, food, housing, homemaker services, home-delivered meals, and supplementary dietary assistance
    - Rental or purchase of Durable Medical Equipment

- Rental or purchase of medical appliances (e.g., braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, or air conditioners, and similar services, appliances, and devices
- Prescription drugs, except as covered under the prescription drug benefit
- Provided by family members, relatives, and friends
- An Enrollee's transportation, including services provided by voluntary ambulance associations for which the Enrollee is not obligated to pay
- Emergency or non-emergency ambulance services
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy and/or social services
- Services provided to individuals (other than an Enrollee released from an inpatient maternity stay) who are not essentially homebound for medical reasons
- Visits by any provider personnel solely for the purpose of assessing an Enrollee's condition and determining whether or not the Enrollee requires and qualifies for home health care services and will or will not be provided services by the provider

55. Treatment of obesity, including, but not limited to:
    - Weight management programs
    - Dietary aids, supplements, injections, and medications (except as covered per Keystone First – CHIP's Drug Formulary)
    - Weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician
    - Group nutrition counseling
    - Surgical procedures specifically intended to result in weight loss (including bariatric surgery)
56. Services or treatment related to an elective abortion — an abortion that is the voluntary termination of pregnancy other than one which is necessary to prevent the death of the woman, or to terminate a pregnancy that was caused by rape or incest
57. The diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program
58. The diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders
59. For Prescription Drug benefits that are not covered, please refer to the Non-Covered Medications section of this manual.
60. For Dental Care benefits that are not covered, please refer to the Dental Provider Supplement for a complete and detailed list.
61. The following are not covered under the Vision Care benefits of this program:
    - Vision therapy
    - Special lens designs or coatings, other than those previously described
    - Non-prescription (plano) lenses