

## 6. COVERAGE GUIDELINES

### Prior Authorization

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

- All scheduled hospital admissions
- Medical equipment like wheelchairs and repairs
- Medicines not listed on the Health Partners formulary
- Nurse visits in your home
- Occupational and Physical Therapy, Durable Medical Equipment and Home Health

When Health Partners receives a complete request for prior authorization, we will contact your provider and you by phone within 2 business days from the date we received the request to tell him or her if we approved the service or item requested. A written decision notice will be mailed to your provider and you within 2 business days from the date of our decision. You and your provider can ask that we delay our decision by up to 14 days in order to provide additional information to support the request.

If Health Partners believes that we do not have all the information needed to make a decision, we will ask for the additional information needed from your provider within 48 hours of when we get the request. Health Partners will let you know that we asked your provider for this additional information. Your provider has 14 calendar days to submit the additional information requested. Health Partners will contact your provider by phone with our decision within 2 business days after we get the additional information from your provider. If your provider does not send the additional information within 14 calendar days of our request, then we will base our decision on the information available.

If we do not provide written notice of our decision within 21 calendar days from the date Health Partners first received the prior authorization request, the service or item is automatically approved. You have the right to appeal any prior authorization request that is denied. The written notice will tell you what you have to do to appeal.

Health Partners follows set standards when making a decision about prior authorization or whether a procedure is medically necessary. These standards are called utilization review guidelines and clinical criteria. Your provider can get a copy of these guidelines and criteria used in reaching our decision by calling the Provider Services Helpline.



You may also get a copy of these materials by contacting our Member Relations department at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579.

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

If your provider fails to call Health Partners for a service requiring prior authorization, and you receive the service anyway, you are not responsible for payment. The only time you are responsible for payment is when you sign the form from your provider, clearly stating your responsibility for payment.

## Payment Denials

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

- The service(s)/item(s) were provided without required authorization.
- The service(s)/item(s) were not a covered benefit for you.

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

## Medical Necessity

Health Partners will pay for healthcare services and benefits not generally covered by Health Partners, but covered under the PA Medical Assistance Program, if they meet any one of the following standards:

1. The service or benefit you are requesting, will, or is reasonably expected to, prevent the start of an illness, condition or disability.
2. The service or benefit you are requesting will, or is reasonably expected to, reduce or make you feel better about the physical, mental or developmental effects of an illness, condition, injury or disability.
3. The service or benefit will help you achieve or maintain your full capacity to perform daily activities. This is considered in comparison with the functional capacities that are appropriate for members of your age group.

The request for the service(s) or benefit(s) must be put into writing. This is called a Letter Of Medical Necessity (LOMN). Your PCP or provider will prepare the LOMN and provide Health Partners with the supporting information. The decision whether to cover

the services that you request will be made by Health Partners. Health Partners may need additional information from your family members or other doctors who have treated you in order to make our decision.

## Do you know about the Clinical Sentinel Hotline?

The Clinical Sentinel Hotline (CSH) is operated by the Department of Public Welfare (DPW) to make sure that your requests for medically necessary care and services sent to Health Partners and your Behavioral Health MCO are responded to in a timely manner. The CSH helps all Medical Assistance consumers who are enrolled in the HealthChoices Program.

The CSH allows members to speak to nurses who work for DPW. If you or your healthcare provider request medical care or services, and Health Partners or your Behavioral Health MCO has not responded in time to meet your needs, call the CSH. You can also call the CSH if Health Partners or your Behavioral Health Plan has denied you medically necessary care or services and will not accept your request to file a grievance. You can also call the CSH if you are having trouble getting shift home health services that have been authorized by Health Partners.

You can call the CSH Monday through Friday between 9:00 a.m. and 5:00 p.m. To reach the CSH, call 1-800-426-2090. The CSH cannot provide or approve urgent or emergency medical care. If you believe you need urgent or emergency care, you should call your PCP or go to your local hospital.

## How Health Partners Covers New Services

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

1. We receive a provider's request for a service or item.
2. We ask the provider to give us a letter that tells us all the details about the service or item and that also explains why the member needs the service or item.
3. We perform a web-based literature search to find out more details about the service or item. These details could include:
  - Whether the service or item was approved by the Food and Drug Administration;

- If other providers have used the service or item and wrote about how it worked for them;
  - Whether the service or item is accepted as useful by other providers. If a literature search does not yield relevant information about the service or item, we contact medical experts directly to get details about the service or item.
4. After the details of the service or item are provided to us from either the literature search or the medical expert, one of our Medical Directors here at Health Partners reviews the details about the service or item. After review, the Health Partners Medical Director makes a decision about whether the service or item should be covered.

These steps help ensure that the service or item is both safe and helpful for you. Experimental services or procedures are not covered under Health Partners' benefit package.

## **If You Move or Change Your Phone Number**

If you move out of the county or the state or you change your phone number, you must let your caseworker know at your local County Assistance Office. You can also notify DPW about an address or phone number change by calling their Customer Service Center toll free at 1-877-395-8930.

Please also notify Health Partners by calling our Member Relations department at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579. (Please see information on Member Responsibilities in section 8.) In general, however, we must continue to use your "official" address supplied by the Department of Public Welfare until you correct your address through your caseworker.

However, you may stay with Health Partners if you move to an area within Bucks, Chester, Delaware, Montgomery or Philadelphia counties in Southeastern Pennsylvania. Even if you move to another location within the same county, you must tell your case worker as soon as possible.

## **Family Size Changes**

If your family size changes, please call the Health Partners Member Relations department, at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579. You should also talk with your caseworker at your local County Assistance office right away.