

6 Health Partners Provider Manual Utilization Management



Purpose: This chapter provides an introduction to Health Partners' Utilization Management team and the guidelines and criteria used by the department to achieve optimal benefit utilization for our members.

- Topics:**
- Health Partners' commitment to providing appropriate medical care for members
 - Prior authorization rules and guidelines
 - Utilization Management decision process and criteria
 - Appeals process

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Overview

Utilization management is a process that monitors the use of a comprehensive set of integrated components including, but not limited to, the following:

- pre-certification review
- admission review
- concurrent review
- continued stay review
- retrospective review
- discharge planning
- bill review
- individual medical case management

The Utilization Management department works in conjunction with our medical providers to determine medical necessity, cost effectiveness, and conformity to Interqual criteria so that members receive optimal use of their benefit plans.

Providing Appropriate Medical Care for Members

At Health Partners, we are committed to providing our members with the most appropriate medical care for their specific situations. To achieve this goal, our utilization management decisions are based on medical necessity, appropriateness of care, and whether an item is medically necessary or considered a medical item. This means Health Partners does not compensate practitioners or other individuals conducting utilization review for denials of needed coverage or service. In addition, we do not provide financial incentives for utilization management decision makers that encourage denials of coverage or service.

Prior Authorizations

The following information is provided to Health Partners/KidzPartners members so that they are aware of the prior authorization process and timeframes. If you, as a provider, have any questions about the information below, please call the Provider Services Helpline at **215-991-4350** or **1-888-991-9023**.

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
- Outpatient Physical Therapy/Occupational Therapy/Speech Therapy
- Homecare

The timeframe in which Health Partners has to respond to prior authorization requests are as follows.

When Health Partners receives a complete request for prior authorization, we will contact you by phone within 48 hours (Health Partners) or two business days (KidzPartners) from the date of our receipt of the request. A written decision notice will be mailed to you within two business days from the date of our decision.

If Health Partners believes that we do not have all the information needed to make a decision, we will request the additional information needed from your provider within 48 hours (Health Partners) or two business days (KidzPartners) of our receipt of the request. If your provider does not send the additional information within 14 calendar days of our request for more information, then we will base our decision on the information available.

If you do not receive written notification of our decision within 21 calendar days from the date Health Partners received the prior authorization request, the service or item is automatically approved. Additionally, Health Partners/KidzPartners members have the right to appeal any prior authorization request that was denied within the required timeframes.

Prior Authorization Guidelines

For Health Partners members, prior authorization by Health Partners' Inpatient Services department is required for all elective hospitalizations, transfers to non-participating facilities, skilled nursing admissions, acute rehab

admissions, inpatient hospice admissions, and PET scans. Prior authorization is also required for certain SPU/ Ambulatory services (see Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures on page 6-7).

For KidzPartners members, prior authorization by Health Partners' Inpatient Services department is required for all elective hospitalizations (including Mental Health), transfers to non-participating facilities, skilled nursing admissions, acute rehab admissions, inpatient hospice admissions, PET scans, MRIs, and SPU services.

For both programs, requests for elective admissions and transfers to non-participating facilities not authorized by Health Partners before admission will be denied for payment. A denial letter will be issued for all elective admissions and transfers to non-participating facilities not authorized by Health Partners. For denial reconsideration, the facility must submit, within thirty days, a letter of appeal detailing why prior authorization has not been obtained. The address for appeals is:

Attn: Utilization Management/Appeals
 Health Partners
 901 Market Street, Suite 500
 Philadelphia, PA 19107

Health Partners will respond to the appeal for medical necessity within 30 days. If not overturned, a second appeal must be submitted by the facility within 30 days of the first level decision notification.

All administrative denials are to be addressed to:

Attn: Director, Inpatient Services
 Health Partners
 901 Market Street, Suite 500
 Philadelphia, PA 19107

In the Health Partners program, certain Short Procedure Unit (SPU)/Ambulatory procedures are subject to scrutiny because they are often performed for cosmetic purposes (and so are excluded from coverage), rather than for medical necessity reasons. As a result, if these services are billed, medical records will be requested to validate the medical necessity of the procedure.

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

| Code | Description |
|-------|--|
| 30430 | Rhinoplasty for Nasal Deformity |
| 30462 | Rhinoplasty for Nasal Deformity |
| 67930 | Suture of Recent Wound, Eyelid |
| 67935 | Suture of Recent Wound, Eyelid |
| 67938 | Removal of Embedded Foreign Body, Eyelid |
| 67950 | Canthoplasty |
| 67961 | Excision and Repair of Eyelid |
| 67966 | Excision and Repair of Eyelid |
| 67971 | Reconstruction of Eyelid |

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

| Code | Description |
|-------|---|
| 67973 | Reconstruction of Eyelid |
| 67974 | Reconstruction of Eyelid |
| 67975 | Reconstruction of Eyelid |
| 67999 | Unlisted Procedure, Eyelid |
| 19328 | Removal of Intact Mammary Implant |
| 19330 | Removal of Mammary Implant Material |
| 19340 | Immediate Insertion of Breast Prosth Follow |
| 19342 | Delayed Insertion of Breast Prosth Follow |
| 19350 | Nipple/Areola Reconstruction |
| 19355 | Correction of Inverted Nipples |
| 19357 | Breast Reconstruction, Immed or Delay |
| 19361 | Breast Reconstruction with Latis Dorsi Flap |
| 19364 | Breast Reconstruction with Free Flap |
| 19366 | Breast Reconstruction with Oth Tech |
| 19367 | Breast Reconstruction with Trans Rect |
| 19368 | Breast Reconstruction with Microvas Anast |
| 19369 | Breast Reconstruction with Trans Rect |
| 19370 | Open Periprosthetic capsui, Breast |
| 19380 | Revision of Reconstructed Breast |
| 19396 | Preparation of Moulage for Custom Breast |
| 11960 | Insertion of Tissue Expander With |
| 11970 | Replacement of Tissue Expander |
| 11971 | Removal of Tissue Expander Witho |
| 54406 | Removal of all components of a Mult |
| 54408 | Repair of Component (s) of a Multi-C |

Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures

| Code | Description |
|-------|-----------------------------|
| 54415 | Removal of a Non-Inflatable |
| 54152 | Circumcision except newborn |
| 54161 | Circumcision except newborn |

Note: All SPU services for KidzPartners members require prior authorization.

How to Obtain Prior Authorization

The following section provides guidelines for properly obtaining a prior authorization from Health Partners.

For elective admissions and transfers to non-participating facilities, the PCP, referred specialist, or hospital must call Health Partners' Inpatient Services department (see Table 1: Service Department Contact Information on page 1-13). These requests for prior authorization must be made before the anticipated admission. Please include the following:

- Member's name and Health Partners or KidzPartners ID number
- Scheduled date of hospital admission
- Anticipated length of stay for hospital admission
- Name of attending physician
- Diagnosis (be as specific as possible)
- Procedure (be as specific as possible)
- Supporting clinical/medical information for requested procedure
- Admitting hospital

For Home Care and Physical Therapy/Occupational Therapy/Speech Therapy authorization, please fax requests to the Outpatient Services department at **215-967-4491**.

For DME and Transport (ambulance) authorization, fax requests to **215-849-4979**.

Note: Due to circumstances regarding member eligibility and timeliness standards, an authorization is not a guarantee for payment.

Criteria for UM Decisions

Health Partners uses available InterQual criteria for the review and decision making of

- elective and emergent inpatient admissions
- SNF/rehab admissions
- outpatient rehab services (occupational therapy, physical therapy and speech therapy)
- home care/hospice
- SPU services
- radiology services

- durable medical equipment

Providers can request a copy of specific Inpatient Criteria, or information about criteria by calling Health Partners Inpatient Services (UM Manager) at 215-991-4188. To request a copy of specific Health Partners Outpatient Criteria or information about criteria, please contact the Outpatient Services Manager at 215-967-4566. For prior authorization, please call 215-967-4690 or 1-866-500-4571 (toll free).

Obtaining UM Assistance After Business Hours

All admissions are to be called in to Health Partners' Inpatient Services department during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m.

Note: *All after-hours referrals should be directed to participating facilities. If providers require assistance for urgent issues after business hours, please call **215-967-4690** or **866-500-4571** and leave a message, which will be forwarded to an on-call nurse case manager. If services (including transfers) cannot be obtained from a Health Partners participating provider, these services must be prior authorized.*

Transportation

Ambulance transportation costs under \$500 per claim line do not require authorization. Transportation services that will be billed exceeding \$500 per claim line require prior authorization from the Outpatient Services department.

Transfer Admissions

All hospital transfers should be directed to Health Partners/KidzPartners participating facilities. If services are not available within the network, prior authorization is required prior to the transfer. Transferring facilities can obtain prior authorization by calling Inpatient Services during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m (see Table 1: Service Department Contact Information on page 1-13).

If providers require assistance after business hours, call Inpatient Services and leave a message, which will be forwarded to an on-call nurse case manager.

Elective Admissions

All elective hospital admissions should be performed by a Health Partners/KidzPartners participating physician. To maximize continuity of care, the PCP or specialist should direct care to the PCP's affiliated health system. Please refer to your directory or PROVIDER Plus+, our online Provider Directory, for more information.

The PCP issues a referral/script for elective hospital admissions to the admitting physician. Health Partners' Inpatient Services department issues a verbal authorization (including an authorization number) to the hospital when prior authorization is approved.

Requests for elective admission or SPU service at a non-participating hospital will be considered only when the service is not available at a participating hospital or ASC. All requests for services at non-participating facilities will require written documentation noting the clinical and other circumstances involved.

Emergent Admissions

All admissions, whether elective or urgent, must be reported to the Health Partners Inpatient Services department within two business days of admission. This notification must include an initial clinical review. Failure to meet this time frame will result in a denial for untimely notification.

Emergency Care

Emergency care in emergency rooms and emergency admissions are covered in full by Health Partners for both participating and non-participating facilities, with no distinction for in or out -of-area services. Member is not responsible for any payments.

Non-par follow-up specialty care for an emergency is covered by Health Partners, but Health Partners staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible. Member is not responsible for any payments.

Concurrent Review Process

All hospitals that are contracted on a DRG basis will contact Inpatient Services within two business days. Using Interqual® ISD criteria, the admission is reviewed and if it meets criteria, the admission is approved. Once approved, a next review date will be given. When the “working DRG” trim point has been met, then daily reviews are to be conducted until discharge. It is the responsibility of the hospital's case management department to contact Health Partners' Inpatient Services department with discharge dates and disposition of the patient. If the date of the admission procedure changes, then Health Partners will need to be notified so that the authorization can match the incoming claim.

Hospitals contracted for per-diem reimbursement are responsible for calling the Health Partners Inpatient Services department within two (2) business days. The Inpatient Services department performs daily reviews. If the chart is unavailable to conduct a review, then the Health Partners case manager must be notified and a retrospective review of that day will be conducted the next business day.

Failure to provide clinical information by the next assigned review date will result in a denial for untimely clinical review.

Medical necessity for acute care hospitals is determined by application of Interqual® ISD criteria. Health Partners does not reimburse acute care hospitals for services that do not require acute hospital levels of care. If the Inpatient Services department decision denies or reduces acute hospital levels of care, a written notice of denial is issued to the hospital. The notice includes instructions for pursuing an appeal of this determination. The HP Medical Directors are available to discuss utilization review decisions by calling **215-967-4570**.

A facility that has been denied services can also submit a letter of appeal and a copy of the medical chart within 30 calendar days to

Attn: Inpatient Services/Appeals
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107.

The PCP (or the covering hospital physician) should make rounds on admitted patients regularly regardless of the provider admitting the patient. Health Partners will look to the PCP for assistance in ensuring appropriate utilization of hospital services.

In the event of a serious or life-threatening emergency, the member should be directed to the nearest emergency facility.

Notification of Discharge/Discharge Management

Clinical reviews of all types of inpatient admissions are required to avoid administrative denials. Discharge date and disposition must be reported to Health Partners' Inpatient Services department within one business day from discharge to promote effective case management when needed, and to avoid claim suspension issues.

Health Partners will continue to look to the PCP for all issues related to appropriate utilization. PCPs are responsible for coordinating follow-up care after hospital discharge. They may refer members to participating specialists when this is medically appropriate. The first, post-surgical follow-up visit is included in the initial referral for surgery. Referral to a specialist or surgeon does not relieve the PCP of his or her responsibility to remain involved in the care of the member.

HealthCare Management System

The HealthCare Management department is composed of several units, including:

- Inpatient Services Department
- Special Needs Unit
- Outpatient Services Department
- Disease Management (CHF/Diabetes/Asthma)
- Baby Partners Perinatal Program

These units work together to assist providers in promoting healthy outcomes for our members while ensuring appropriate utilization of available services. The Care Management staff is comprised of teams targeted by hospital affiliation and specialty (i.e. high risk prenatal, pediatrics, and other disease states such as congestive heart failure).

The multidisciplinary team assists providers and members with appropriate connectivity to education and resources to promote healthy living and preventive health management.

The Special Needs Unit (SNU) serves as a critical link between members and doctors. The unit also serves as a link with other providers, in order to meet the special needs of Health Partners/KidzPartners members. Within the HealthCare Management department, the SNU works with Inpatient Services and Case Management to provide continuity of care and coordination of care for our members. Members can self-refer to the SNU or be referred via any external providers/agencies, or from internal departments such as Inpatient Services and/or Member Relations.

If providers require assistance with coordination of care, please call any of the departments listed. For more information, see Service Department Contact Information on page 1-13.

Mental Health Services

Health Partners - Medicaid: For Health Partners members, the Behavioral Health Managed Care Organization (BHMCO) for the county in which the member lives is responsible for psychiatric care. For more information, see Service Department Contact Information on page 1-13.

KidzPartners- CHIP: MHNNet is Health Partners' behavioral health subcontractor for our KidzPartners program. All services other than emergency services must be prior authorized by MHNNet. Prior authorization can be obtained by calling MHNNet (see Table 1: Service Department Contact Information on page 1-13).

Substance Abuse Treatment

Health Partners - Medicaid: For Health Partners members, the HealthChoices Behavioral Health Managed Care Organization (BHMCO) for the county in which the member lives is responsible for substance abuse services.

KidzPartners- CHIP: MHNNet is Health Partners' behavioral health subcontractor for our KidzPartners program. Substance abuse services may be accessed by calling **800-835-2094**. All services must be prior authorized. MHNNet must be contacted within 24 hours of an emergency admission

Coordination with Behavioral Health

Health Partners - Medicaid: The Special Needs Unit (SNU) Case Managers can collaborate with the appropriate Behavioral Health Managed Care Organization (BHMCO) to coordinate psychiatric services and/or drug and alcohol treatment for any Health Partners member. A case manager will assist members interested in treatment by coordinating conference calls with the appropriate providers to ensure that the referral is completed.

In addition, the SNU assists members with transportation to either behavioral or physical medical appointments by helping them complete application to the Medical Assistance Transportation Program (MATP). MATP coordinates rides to and from these appointments for Medical Assistance recipients. MATP offices are located in Chester, Bucks, Delaware, Montgomery, and Philadelphia counties.

Contact the Special Needs Unit (see Table 1: Service Department Contact Information on page 1-13).

KidzPartners- CHIP: Behavioral health services are covered benefits in the KidzPartners program. SNU Case Managers are available to help KidzPartners members with any special coordination needs.

Skilled Nursing Admissions

Health Partners - Medicaid: Members in a licensed skilled nursing or intermediate care facility are covered by Health Partners for up to 30 days (including hospital reserve or bed hold days). Members can be admitted to skilled or intermediate care facilities directly from the community.

KidzPartners- CHIP: For KidzPartners, there is a limit of ninety days annually for inpatient medical, skilled nursing and mental health combined.

All admissions will require authorization by the Inpatient Services department for reimbursement. Requests for skilled nursing admissions should be faxed to **215-991-4125**.

For Health Partners members only, the 30-day period includes any hospitalizations or transfers between skilled nursing facilities (SNFs). Health Partners will submit an involuntary disenrollment request of the member from the plan to DPW if the member has not been discharged from the SNF to a community placement.

Medicaid Program Exception Process

Health Partners, under extraordinary circumstances, will authorize a medical service or item that is not one for which the Medicaid Program has an established fee, or will expand the limits for services or items that are listed

on the Medicaid Program Fee Schedule. If a provider concludes that lack of the service or item would impair the member's health, the provider may request a program exception. A request for program exception must contain sufficient information to justify the medical necessity for all requested services.

Program Exception is allowed for review of requests for:

- Services and items not listed on the Medical Assistance Fee Schedule, if they are types of services/items covered by the Medical Assistance Program and generally accepted by the medical community
- Expansion of coverage limitations for services/items that are listed on the Medical Assistance Fee Schedule
- Coverage under Program Exception is not allowed when the service, item or limits on the service/item is prohibited from payment by statute or regulation.

Medicaid Inpatient Benefit Limit Exception

Inpatient acute hospital benefit limits have been removed from General Assistance (GA) membership benefit packages. Inpatient acute rehabilitation stays will continue to have a benefit limit of one inpatient stay per benefit year.

A request for an exception may be made prospectively, before the service has been delivered, or retrospectively, after the service is delivered. The following timeframes will be adhered to in addressing benefit exception requests:

- Prospective Urgent benefit exception requests: two business days.
- Prospective benefit exception requests : two business days of receipt of complete information . If additional information is required the provider has 14 calendar days to submit information.
- Decision will be rendered within 2 business days of the receipt of additional information with written notification generated within 2 business days of communicating the decision. Written notification is to be received by the member within 21 days.
- Retrospective exception requests: 30 days

Prior authorizations are based on covered services under a given benefits package, medical necessity, and clinical appropriateness using clinical criteria and guidelines that are the accepted standard of care in the medical community. In addition, the physician reviewer must override the criteria when, in his/her professional judgment, the requested service is medically necessary. Individual member assessment must occur. Health Partners will review exceptions to benefit limitations using approved guidelines.

A provider or member can request an exception to the Benefit Limit within the member's MA/GA Benefit Package within 30 days from the date notice is received. A request form will be issued to the member and provider for completion. It details the medical information needed to process the request and make a determination.

The provider should send the completed form and any other information he/she deems important to:

Attn: UM/Benefit Exception
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

Exceptions will be reviewed according to approved guidelines, such as:

- The member has a serious chronic systemic illness or other serious health condition and without the additional service the member's life would be in danger, or
- The member has a serious chronic illness or other serious health condition and without the additional service the member's health will get much worse, or
- The member would need more costly services if the exception is not granted, or
- The member would have to go into a nursing home or institution if the exception is not granted.
- Approved Exceptions will be processed according to the Prior Authorization policy and procedures.

The inpatient benefit limit exception process applies only to Medicaid members not KidzPartners members. Prior authorizations are based on covered services under a given benefits package, medical necessity, and clinical appropriateness using clinical criteria and guidelines that are the accepted standard of care in the medical community. In addition, the physician reviewer must override the criteria when, in his/her professional judgment, the requested service is medically necessary. Individual member assessment must occur. Health Partners will review exceptions to benefit limitations using approved guidelines.

Note: *The inpatient benefit limit exception process applies only to Medicaid members not KidzPartners members.*

Medically Necessary Services

Medical Necessity is whether a treatment, admission, procedure, medical supply or equipment, or any otherwise covered service or supply is medically necessary.

Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review, post-utilization, or (for Medicaid) exception basis, shall be in writing and provided to the member promptly. The determination will be based on medical information provided by the member, the member's family/caretaker and the primary care provider, as well as any other providers, programs, or agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained providers and be appropriate and consistent with the diagnosis and in accordance with generally accepted standards of medical practice.

Medicaid: For Health Partners members, a service or benefit is medically necessary and compensable under the Medical Assistance Program if it meets any one of the following criteria:

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

CHIP: Medical Necessity or Medically Necessary and Appropriate refers to services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Appealing Inpatient Utilization Review Decisions

Any disagreement between Health Partners and a facility concerning concurrent or retrospective denials based on procedural errors or medical necessity/appropriateness, and in which the member received service(s) and is held financially harmless, shall be resolved in accordance with the following appeal procedures:

In the event a case is referred to the Health Partners Medical Director or physician advisor for a determination, and the initial decision is adverse to the facility's request, the facility may request an expedited appeal within 24 hours of the decision by calling 215-967-4570.

The facility will be notified in writing of the expedited appeal decision rendered by the Health Partners Medical Director. The facility shall have thirty (30) calendar days from the date of the written decision notification from the Health Partners Medical Director to request a first level of appeal by submission of the medical record and a letter of appeal, to:

Attn: Utilization Management/Appeals
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

If the denial is upheld in the first level of appeal, then the facility has thirty (30) calendar days from the date of the written notification to request a second level appeal from the Utilization Management Committee at the Appeals address above.

The Utilization Management Committee (UMC) is a subcommittee of the Health Partners Medical Affairs Committee, which serves as a peer review panel and is composed of representatives from Health Partners' participating providers. The Utilization Management Committee responds to second level appeals. The UMC will complete its review within thirty (30) calendar days of receipt of a second level appeal request and supporting documents. The UMC will communicate its decision to Health Partners' Utilization Management department Appeals Coordinator, who will inform the facility in writing of the decision within five (5) business days of the UMC's decision. The decision of the UMC is final; no further right of appeal is provided.

Decision Process for Covering Emerging Medical Technology

Before Health Partners approves new treatments, drugs, or equipment that are still considered experimental, we want to make sure that these new advances are safe and effective. When we receive a provider's request, the request goes through the following processes:

- We request that the provider submit a detailed narrative description of the service or item.
- We check to ensure that existing Federal and State Regulations do not preclude coverage.
- We research available data via online medical resources to obtain more detailed information on the service or item including, but not limited to:
 - FDA approval status
 - Peer-Review Literature
 - Whether the service/item is considered the accepted standard of care in the medical community.

If current clinical reference websites do not have information regarding the requested service or item, Health Partners contacts medical experts directly to obtain pertinent information.

A Health Partners Medical Director reviews the information obtained from current clinical reference guidelines (or medical experts) and determines if the service or item should be covered.

Member Appeals of Denied Services

Members (or their parent/guardian on their behalf) have the right to appeal any decision about payment for, or failure to arrange or continue to arrange for, what they believe are covered services (including non-covered benefits). For more information, see Provider-Initiated Member Appeals (Act 68) on page 10-7 and see Medicaid Member Grievance & Complaint Process on page 11-12.

Out-of-Plan Referrals/Scripts

Health Partners strongly discourages referrals/scripts to non-participating providers. Treatments or services available within the Health Partners network should be performed by a participating provider. Out-of-plan referrals/scripts require prior authorization from Health Partners' Inpatient Services or Outpatient Services department. Failure to obtain prior authorization will result in a denial of payment. Health Partners requires a written request documenting the reason(s) the member cannot be treated within the plan's network. While continuity of care is a consideration, it does not automatically result in authorization of these referrals/scripts.

In accordance with federal access standards, family planning is an exception from the above requirements for Medical Assistance and CHIP members. Members may be referred, or may self-refer, to any family planning provider, regardless of whether the provider participates with the plan. The right of a Health Partners member to choose a health care provider for family planning services shall not be restricted.

Continuity of Care for New Members

Health Partners is responsible for helping new members transition from another Physical Health Managed Care Organization (PH-MCO) or Fee-for-Service health insurer to our health plan.

Health Partners must coordinate and continue to authorize services under the previous provider reimbursement agreement for up to sixty (60) days, as outlined below. This allows the new member to continue services with a provider outside Health Partners' or KidzPartners' provider network during this transition period only. Health Partners must also send written notification to both the member and the nonparticipating provider, confirming that the member wishes to follow this arrangement.

For new members under age 21

Health Partners must honor the number, length, and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 60 days from the date of enrollment with Health Partners/KidzPartners).

For members 21 and older

Health Partners must honor the number, length and scope of services as approved by the prior authorization his/her provider received from the previous plan (for up to 60 days from the date of enrollment with Health

Partners). However, Health Partners may reduce or terminate services prior to the expiration of this period after concurrent clinical review to determine the need for continued services.

If, as a result of the concurrent clinical review, Health Partners authorizes an alternative course of treatment, a reduction, or termination of another MCO's or the Department of Public Welfare FFS program's approved prior authorization, Health Partners must provide proper written notification of the changes to the member and the prescribing provider and honor the member's right to exercise his/her full grievance and fair hearing rights.

If a new member 21 or older is receiving a course of treatment that did not require prior authorization from the member's previous Medical Assistance Fee-for-Service plan or another PH-MCO, continuation of the service must occur without interruption even if Health Partners would ordinarily require prior authorization for that service. This would apply to the transitional period of up to sixty (60) days from the member's date of enrollment with Health Partners.

In each of the situations outlined above, the 60-day period may be extended if Health Partners' Medical Director finds it to be clinically appropriate.

Pregnant members

If a new (and pregnant) member is already receiving care from an out of network OB-GYN Specialist at the time of enrollment, she may continue to receive services from that specialist throughout the pregnancy and delivery-related postpartum care. This coverage period may also be extended if Health Partners' Medical Director finds it to be clinically appropriate.

Health Partners may recruit the new member's nonparticipating provider to our network, or arrange for the service to be delivered by a participating provider if the enrollee consents to the change.

Per Department of Health regulations, providers must agree to Health Partners' terms and conditions prior to providing service. If the provider does not agree before rendering the service, he/she is required to notify the member of that fact.

Specialist as PCP

A member with a life-threatening degenerative or disabling disease or condition, or a provider or advocate acting on the member's behalf, may request that his/her specialist (with clinical expertise in treating the disease or condition) be allowed to serve as the member's PCP. Health Partners' evaluation of such a request will include a written letter of medical necessity (LOMN) from the specialist and a determination by our Medical Director.

Health Partners' Special Needs Unit (SNU) should be contacted to initiate the request (see Table 1: Service Department Contact Information on page 1-13). The SNU case manager will confirm that both the member and the specialist agree to the request, then will ask that the specialist provide a supporting LOMN. On receipt of the LOMN, the case manager will forward the request to Health Partners' Medical Director, who will have up to 45 days to make a determination.

The case manager will notify the member and specialist of the determination. If approved, the case manager will also initiate credentialing of the specialist as a PCP. Upon satisfactory completion of the credentialing process, the case manager will notify the member and provider that the requested change is complete.

A specialist seeking to serve as PCP must agree to provide or arrange for all primary care, consistent with Health Partners' preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the member's special need and within the scope of the specialist's training and clinical expertise.

Anti-Gag Policy

The provider may freely communicate with each member regarding the treatment options available to him/her, including information regarding the nature of treatment, alternative treatment, risks of alternative treatments, or the availability of alternative therapies, consultation, or tests, regardless of benefit coverage limitations. The provider is expected to educate patients regarding their health needs; share findings of the member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms without regard to plan coverage; and recognize that the member has the final say in the course of action to take among clinically acceptable choices. No provision of this Manual or the Participating Provider Agreement shall prohibit open clinical dialogue between the provider and members.

Health Partners' goal is to ensure that all members receive the most appropriate medical care available. Health Partners does not directly or indirectly reward physicians, providers, contracted entities, employees, or any other individuals participating in utilization review decisions for denying or limiting coverage or service. Health Partners also does not provide financial incentives for utilization management decision makers that result in the under-utilization of care or service.

While Health Partners may utilize incentives to foster efficient, appropriate care, it does not employ incentives to encourage barriers to care and service. It is therefore expected that all contracted and delegated physicians and providers as well as employees who deal with utilization review activities make utilization determinations regarding benefits covered by Health Partners based only upon the appropriate use of care and services for the member.

