Jefferson Health Plans

JEFFERSON 200

Ancillary Annual Orientation and Training (AAOT)

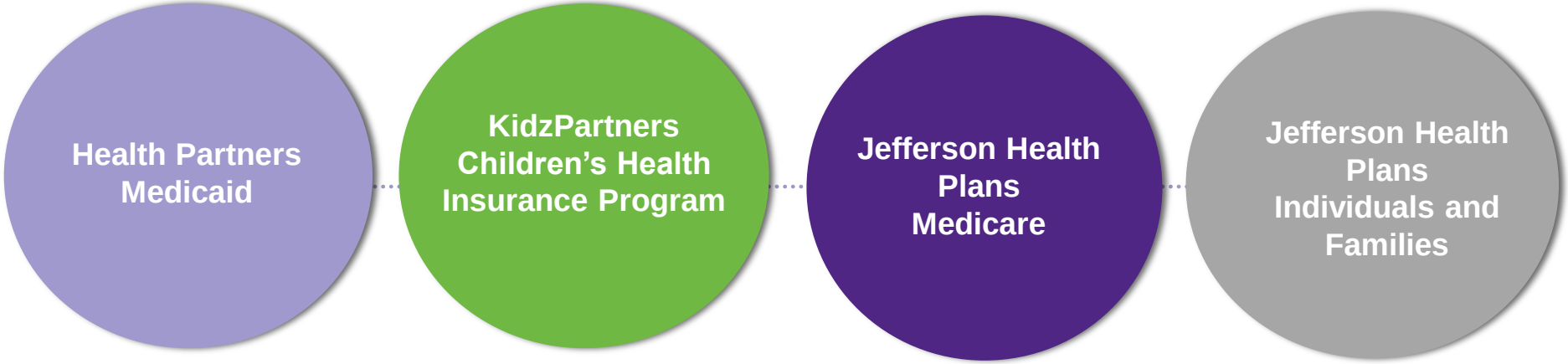
2024

Overview of 2024 Products

Jefferson Health Plans

About Jefferson Health Plans

- Coverage for people of all ages



Medicaid Benefits

Our members have $0 copays in 2024 for covered Medicaid physical health services and prescription drugs.

Jefferson Health Plans provides all the benefits of Medicaid, including:

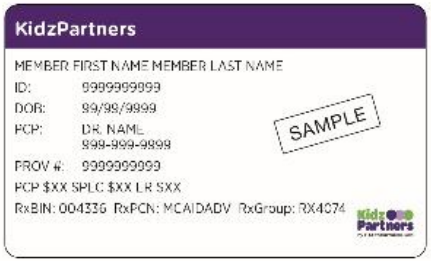
- Primary care doctor and specialist office visits
- Hospital services
- Lab services
- Prescriptions
- Routine dental care for children and adults
- Checkups and immunizations and for children and adults
- Routine eye exams for children and adults
- Glasses and/or contact lenses for all children (two pairs of glasses or contacts, or one pair of each, covered yearly)
- Health Partners members aged 21 years and older are eligible to receive one pair of eyeglasses or contact lenses a year.

Additional Benefits

- Teladoc®, 24-hour medical help line for assistance when you need it
- Fitness center memberships
- Nutrition education and counseling
- Wellness Partners; a health and wellness initiative with free events for the community
- Baby Partners program
- Care Management programs
- Member events and education

Identification Cards 2024

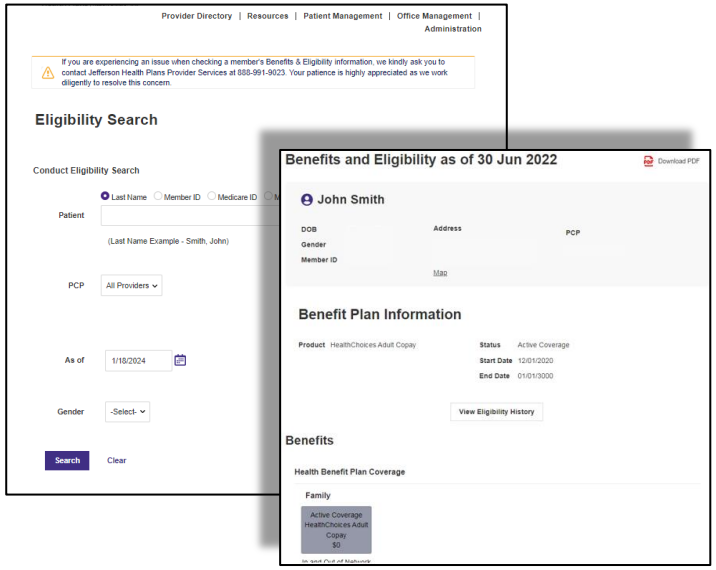
Health Partners Medicaid
(9-digit ID starting with all numerical digits)



KidzPartners CHIP
(10-digit ID starting with a "3" or a "9")

Check out our [2024 Member ID Cards] on our website!

- Check eligibility and benefits through provider portal by clicking [Provider Portal]



2024 Medicare Product Overview - Pennsylvania HMO Plans

- Jefferson Health Medicare is offering seven Medicare Advantage plans with no referrals, expanded supplemental benefits, no medical or Rx deductibles, affordable copays and Part D prescription drug coverage.

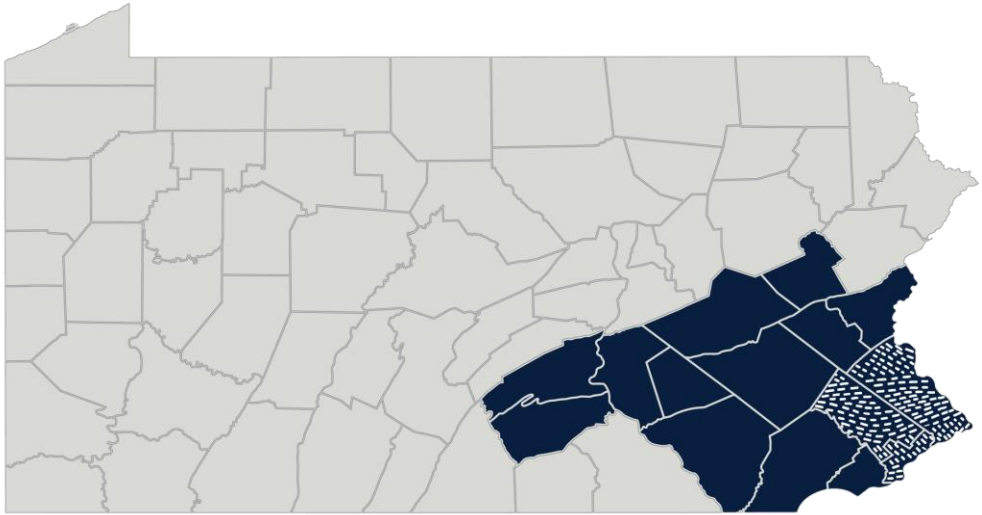
Pennsylvania - HMO Plans		
Complete	Prime	Giveback (New in 2024)

Pennsylvania - PPO Plans	
Flex (New in 2024)	Flex Plus (New in 2024)

Pennsylvania - HMO DSNP Plans	
Dual Pearl (New in 2024)	Special

Where are Jefferson Health Plans' Medicare Plans Available?

- Pennsylvania



- Berks County
- Bucks County
- Carbon County
- Chester County
- Cumberland County
- Dauphin County
- Delaware County
- Lancaster County
- Lebanon County
- Lehigh County
- Montgomery County
- Northampton County
- Perry County
- Philadelphia County
- Schuylkill County

Medicare Advantage
Complete (HMO-POS)
Prime (HMO-POS)
Flex (PPO)*
Flex Plus (PPO)*
Special (SNP HMO)

Medicare Advantage
Complete (HMO-POS)
Prime (HMO-POS)
Giveback (HMO-POS)*
Flex (PPO)*
Flex Plus (PPO)*
Special (SNP HMO)
Dual Pearl (SNP HMO)*

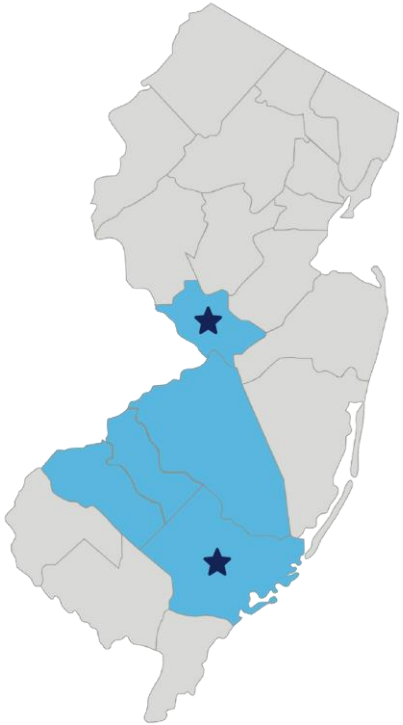
2024 Medicare Product Overview – New Jersey HMO Plans

New Jersey - HMO-POS Plans	
Silver	Platinum

- Our Medicare Advantage plans offer more benefits than Original Medicare including low-cost doctor visits and prescription drug coverage, plus dental, vision and hearing benefits
  - If you would like to learn more about our Medicare plans for PA & NJ, visit www.jeffersonhealthplans.com/medicare/

Where are Jefferson Health Plans' Medicare New Jersey Plans Available?

New Jersey



★ Atlantic County
Burlington County
Camden County
Gloucester County
★ Mercer County

Medicare Advantage
Silver (HMO-POS)
Platinum (HMO-POS)

★ **New Counties in 2024**

Identification Cards 2024

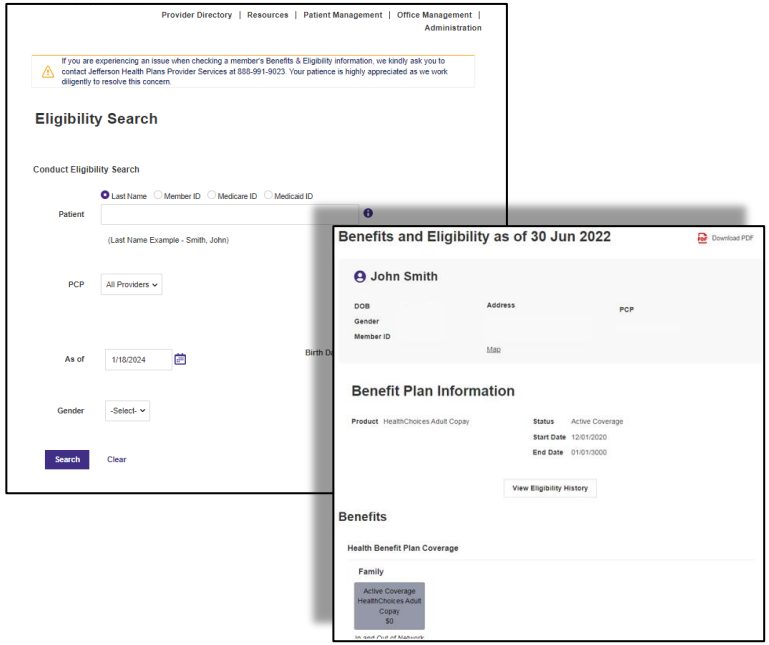
Jefferson Health Plans Medicare *HMO and PPO

*to be identified in the plan name on the card

(7-digit ID number starting with a “5”)

- Check out our 2024 Member ID Cards on our website!

- Check eligibility and benefits through provider portal by clicking Provider Portal



Individuals & Families Plans – New in 2024

- Two Bronze plans (targeting lower premium Bronze plan)
- Six Silver plans (Silver benchmark plan)
- Two Gold plans

Bronze Plans	
HMO + $0 Deductible	Total + HMO

Silver Plans		
$ Deductible + HMO	Balanced + HMO	Total + HMO

Gold Plans	
$0 Deductible + HMO	Total + HMO

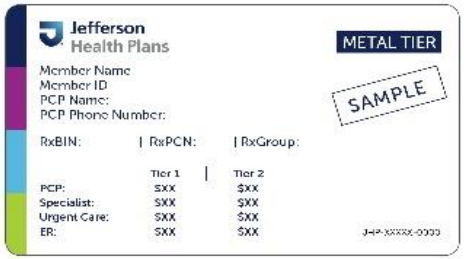
Jefferson Health Plans offers off exchange products for all the various plans on exchange in addition to 3 additional off exchange products at the Silver metal level known as our Value products

In 2024, Jefferson Health Plans is Entering the ACA Marketplace!

Jefferson Health Plans for Individuals and Families in Philadelphia, Bucks, and Montgomery Counties will be available both on and off the Pennie exchange in 2024.

Built by insurance experts and backed by Jefferson Health, our plans are priced **competitively** for Pennsylvania's ACA marketplace.

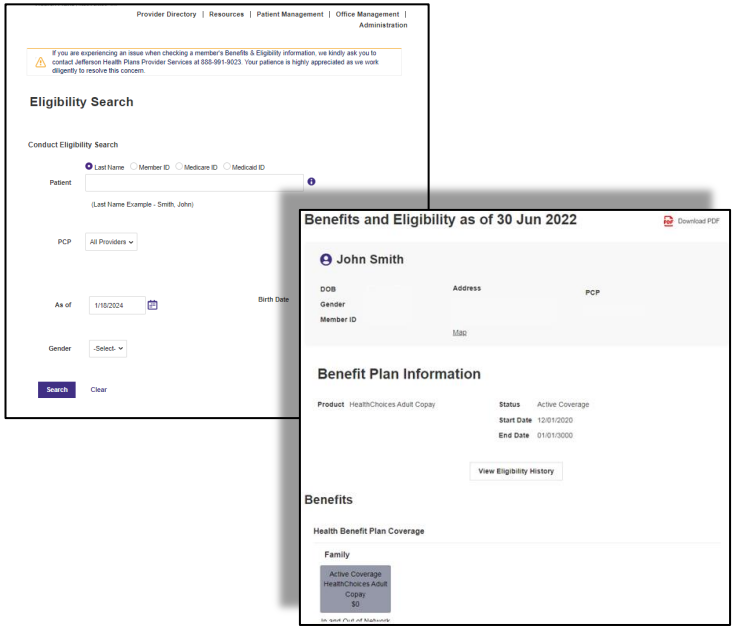
Identification Cards 2024



Jefferson Health Individuals and Families
(12-digit ID, starting with a “J”)

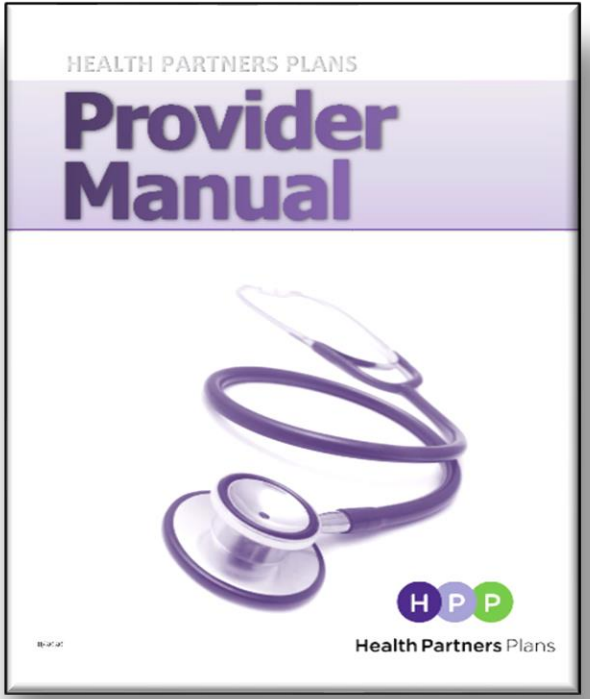
- Check out our 2024 Member ID Cards on our website!

- Check eligibility and benefits through provider portal by clicking Provider Portal

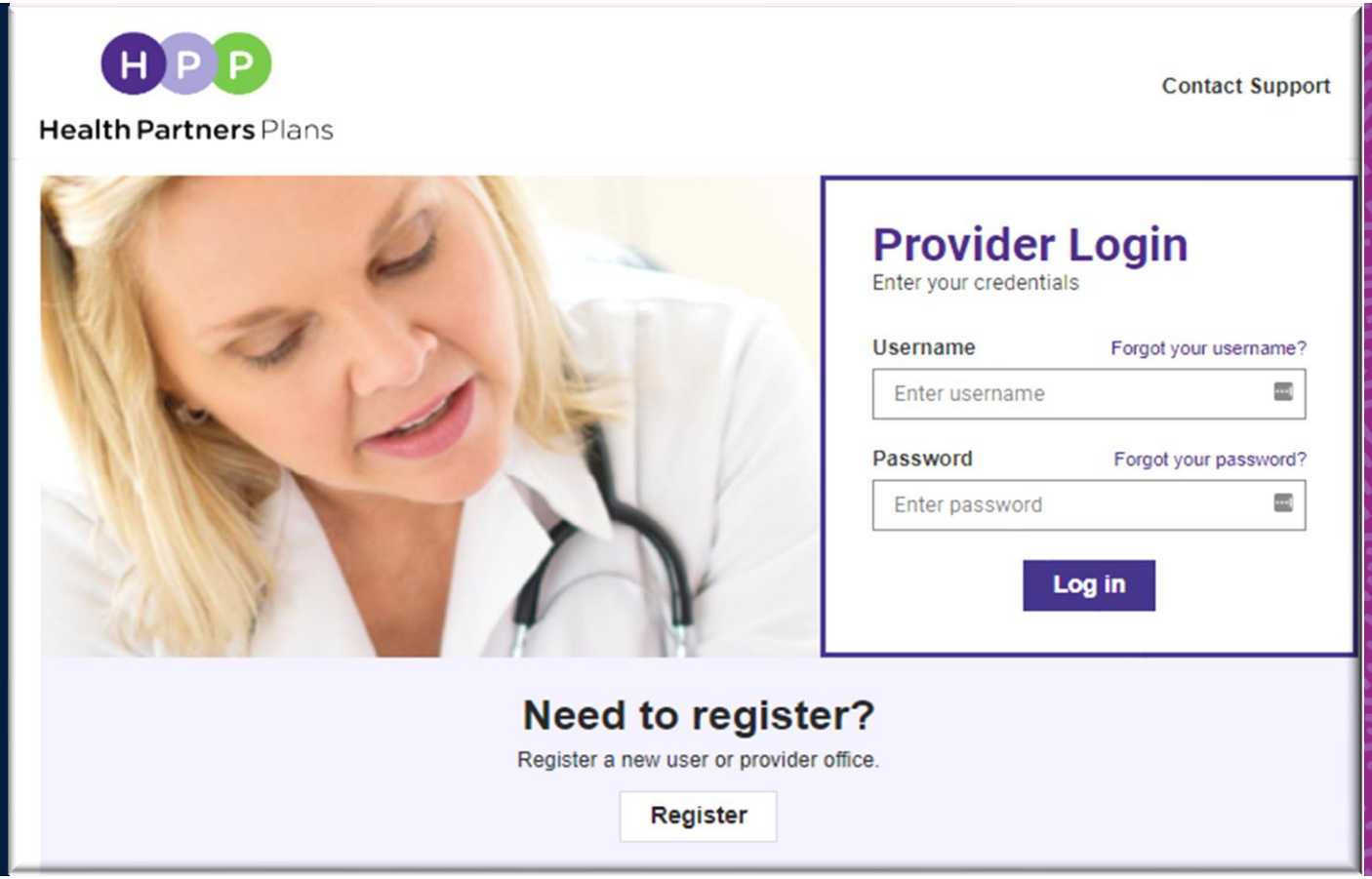


Online Tools

- Welcome Providers
  - Provider Manual
  - Training and Education
  - Provider Portal
  - Provider Directories
  - Formularies
  - Clinical Resources
  - Plan Information
  - Provider Newsletters
  - Quality and Population Health



Provider Portal



Provider Portal

The following transactions and services are available through the provider portal, powered by HealthTrio:

- **Eligibility and Benefits -** It's important to verify a patient's eligibility before rendering services to a member. It's recommended to verify eligibility on the date of service, and each time the patient is seen. Benefit plan information is available on the eligibility screen.

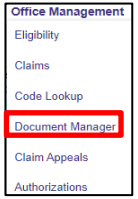
- **Claim Status Inquiry** - Providers can search for claims from the Patient Management and Office Management menus.

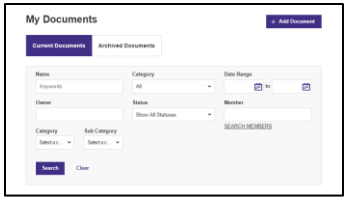
- **Claims Appeals (Reconsiderations)**- Providers can submit claim appeals and check their status within the provider portal. There is an option to appeal claim decision at the top left corner of the screen. To begin an appeal, select **Claim Appeals**. This will open the Appeal Details screen.

- **Authorization Requests** - Allows a provider to enter service requests online for electronic submission to the health plan. We offer electronic entry of Admission, Outpatient, Specialist, Homecare, and Transportation service request types.

Provider Portal

- **Document Manager** - Supports the uploading and sharing of many kinds of documents between users. This feature supports advanced search capability, categorization and archival of documents, linkage of documents to claims and authorizations and comments between users.
  - Care Gap Report
  - QCP Reports
  - Stars Report
  - HEDIS Site Report
  - Member Roster





- **Provider Communications** – Important news about Jefferson Health Plans updates, policy, notifications and educational webinars.
  - If you have a business need for these functions and currently do not have access to provider portal, please click the Register/Access by clicking https://hppprovider.healthtrioconnect.com/app/index.page
- **Resources**
  - Provider Registration Guide (PDF)
  - Local Admin & User Guide (PDF)
  - Initial User Login Guide (PDF)
  - Username and Password Reset Guide (PDF)
  - HP Connect Frequently Asked Questions (PDF)

Claims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M−
MR
MC
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9
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SEVEN BAHT AND
Total Amoun
ment until the buyer has done.

Change Health Care Cyber Security Incident

- On February 21, 2024, Jefferson Health Plans was alerted by **Change Healthcare** about a cyber security incident that disrupted Change Healthcare's ability to deliver services. This impacted providers who use Change Healthcare to send member eligibility verifications, 835/837 files and paper-to-electronic claims scanning.

- Jefferson Health Plans has been working diligently with our internal business partners and with Smart Data Solutions (SDS) to implement alternatives to these services. As of March 13, 2024, connectivity was established with SDS for claims submissions.
  - Please visit our website at https://www.healthpartnersplans.com/providers for up-to-date FAQs/information.

Smart Data Solutions

- **Smart Data Solutions** (SDS) is fully connected to accommodate Electronic Data Interchange (EDI) claim submissions for our two Payor IDs:
  - Jefferson Health Plans:
    - Health Partners (Medicaid), KidzPartners(CHIP), Jefferson Health Plans Medicare HMO, Jefferson Health Plans Individuals and Family: **Payor ID#80142**
    - Jefferson Health Plans Medicare PPO: **Payor ID#RP099**
- Providers may sign-up through the SDS provider portal by emailing SDS directly at stream.support@sdata.us. Please be sure to include the information noted in the next slide in your request.

Smart Data Solutions

- When submitting to Smart Data Solutions, include the following information:
  - First Name
  - Last Name
  - Email
  - Phone
  - Organization name, NPI, and Tax ID
  - The Jefferson Health Plans Payor ID(s) listed on the previous slide.

If you have any questions, please contact the Provider Services Helpline at 1-888-991-9023 (Monday to Friday, 9 a.m. to 5:30 p.m.)

Filing Claims

Mailing Address **Please note claims mailing address is temporary until a PO Box is established with SDS.

Medicare PPO
901 Market St. Ste 500
Philadelphia, PA 19107

Medicaid, CHIP, Medicare HMO/DSNP, *Individual and Family*
901 Market St. Ste 500
Philadelphia, PA 19107

Electronic Filing

Electronic Payor ID for Medicare PPO: RP099
Electronic Payor ID for Medicaid, CHIP, Medicare HMO/DSNP, *Individual and Family*: 80142
Clearing House: Smart Data Solutions
EFT Payments and Remittances: ECHO Health, Inc.
EDI Support: EDI@Jeffersonhealthplans.com

Timely Filing

Initial Submissions: 180-days from Date of Service or Discharge Date
Reconsiderations: 180-days from the date of Jefferson Health Plans' Explanation of Payment (EOP)
Coordination of Benefits: 60-days from date of other carriers (EOP)

Claim Payment Policy

Policy Bulletin Library provides reimbursement rules and billing guidelines necessary to ensure timely and appropriate payment

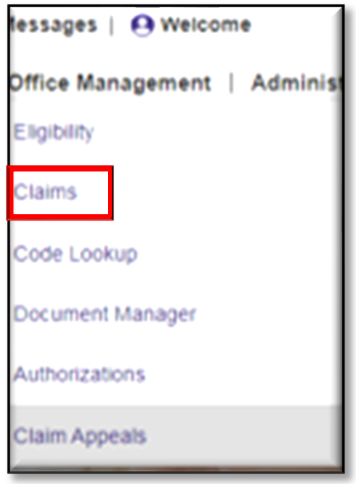
Behavioral Health Claims

Must submit to Behavioral Health MCO
For latest listing of BH-MCO's by county, please visit DHS HealthChoices Behavioral Health-MCO
For KidzPartners (CHIP) and Health Partners Medicare contracts with Magellan Behavioral Health

Claim Status Inquiry

- Providers can use the **Provider Portal** to view claims.

- **Claim Status Inquiry** - Providers can search for claims from the Patient Management and Office Management menus.



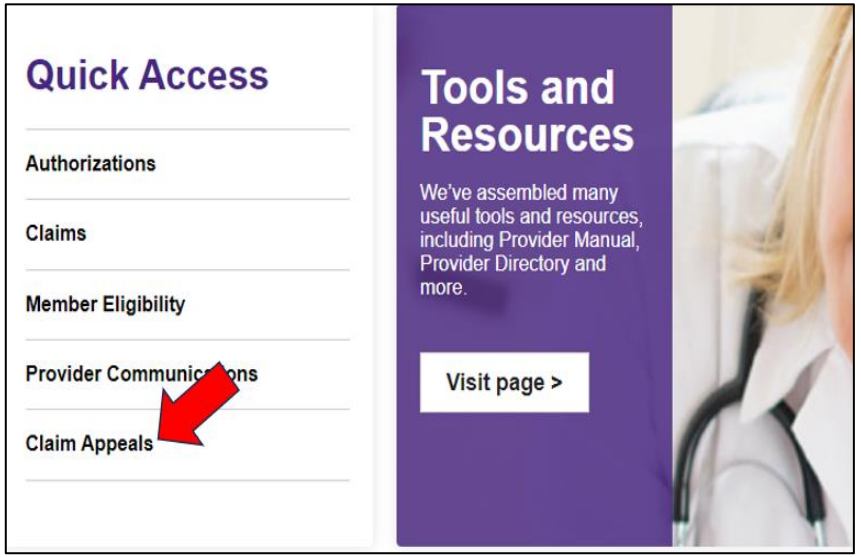
Claims Reconsideration

- Providers can request a reconsideration determination for a claim that may have been paid incorrectly or denied inappropriately. Reconsiderations must be made timely by the requestor.

- Claims reconsideration methods:
  - The **Provider Portal** is the most efficient way to request a reconsideration.
  - Call Jefferson Health Plans' representative to send the claim to be reprocessed, when appropriate.1-888-991-9023, option #1 (Monday to Friday, 8:30 a.m. - 4:30 p.m.).
  - Paper appeals must be mailed to:

    Jefferson Health Plans
    1101 Market Street, Suite 3000
    Philadelphia, PA 19107

- eLearning course: Timely Filing Protocols and the Reconsideration Process



Transportation Claims

- Review your explanation of payment to explain any denial reason codes:
  - The Explanation of Payment (EOP) outlines the adjudication of your claims.
  - Denial reason codes will appear at the line level and claim level of your EOP with the full description of the denial at the bottom of the EOP.

- Here is an example of a common transportation denial reason code:
  - Code PI97

Explanations

Administered by	Code	Description
HealthPartnersPlans	PI97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  - PI97 may appear on your EOP if the mileage payment is considered inclusive to the trip itself.

- If you have any additional questions about mileage/trip claims, please refer to provider contract.
  - For information on Ambulance policy, please visit our Policy Bulletin Library

Encounter Data

Participating providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with a Jefferson Health Plans member.

For professional claims, providers who are registered as home health providers, hospice providers, certified nutritionists, DME, X-ray clinics and renal dialysis providers must include the referring provider on their claim submissions. The data can be submitted in the referring provider loop (2310A) or the ordering provider loop (2420E), whichever is appropriate to your claim situation.

Coordination of Benefits

- Health Partners (Medicaid) is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before Jefferson Health Plans will consider any charges.

- After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payor to Jefferson Health Plans. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.
  - For more information, visit our Provider Manual Chapter 12: Provider Billing & Reimbursement

Community HealthChoices

Resources and Links

- CHC Fact Sheet
- Adult Benefit Package
- Long-Term Services and Supports Benefits Guide
- Coordination With Medicare
- Populations Served By CHC
- Eligibility Verification System (EVS)

Community HealthChoices

Beneficiaries who are enrolled in a CHC plan are 21 or older and have both Medicare and Medicaid, or receive long-term support through Medicaid, There are three Community HealthChoices (CHC) plans:

- PA Health & Wellness (Centene)
- AmeriHealth Caritas (Keystone First CHC/AmeriHealth Caritas Pennsylvania CHC)
- UPMC

Keep in Mind

- Jefferson Health Plans members eligible for CHC were notified by the state that they must enroll with a CHC plan.
- Pennsylvania auto-enrolled members into one of the three plans if they did not choose a plan.
- As a participating provider, you **can** provide services to Health Partners Medicare members even if they are enrolled in a CHC (Medicaid) plan.
- You **do not** need to be participating with CHC plans to provide services to Jefferson Health Plans patients.
- Medicare is the **primary** payer and drives the care.
    - Medicaid benefits are accessed after Medicare benefits have been exhausted.
    - Our Care Coordinator can assist you with coordinating services between Medicare and Medicaid.
    - Medicaid is always the payer of last resort.
- Providers can submit claims to the CHC plans regardless of their contracting status with the CHC plans.

Qualified Medicare Beneficiary (QMB)

- QMB program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries.
  - The law prohibits Medicare providers from collecting Medicare Part A and B coinsurance, copayments and deductibles from those enrolled in the QMB program.
    - For more information, visit The CMS MedLearn Matters article

Balance Billing Dual Eligible Members: Medicare/Medicaid

- Fully Dual Eligible beneficiaries are ***not*** directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).

- Medicaid (CHC) will remain the payer of last resort.

- Providers may not balance-bill participants when Medicaid, Medicare or another form of TPL does not cover the entire billed amount for a service delivered.

- Please note that Jefferson Health Plans Special (HMO SNP) members are fully dual eligible.

Special (HMO SNP) Plan Reminders

- Special plan members have *both* Medicare and Medicaid coverage.
- Special plan members are also referred to as **Dual Special Needs Plan (DSNP)** members.
- You ***do not*** need to be participating with Medicaid Community HealthChoices plans to provide services to a Jefferson Health Plans Medicare member.
- Providers ***can*** submit claims to the CHC plan regardless of their status with the CHC plan.

Credentialing

Pathways for Provider Contracting, Application & Demographics Changes

- Providers must notify, in writing, to the following department for the following:

Credentialing@jeffersonhealthplans.com

- Site relocation- credentialing application and roster is required
- NPI & Promise ID number changes

Contracting@jeffersonhealthplans.com

- Initial contract, roster and application
- Change in group ownership
- Tax ID change or additions
- W-9 form is required

ProviderData@jeffersonhealthplans.com

- Additions/links/terms of hospital based/ facility based/ PT/ OT/Speech providers
- Change in payee information - W9 is required
- Change in hours of operation
- Telephone number change

Change in age restriction

Key Takeaways

- Our goal is to process all credentialing applications within **60 days**, providing all requirements are submitted timely.
- We are required to verify and update your information every 90 days. Our directories are fed by the information you supply.
- It's so important that the state enacted the "No Surprise Act" to ensure directory accuracy.
- For initial contract, roster and application the providers can use the recruitment link below- https://www.healthpartnersplans.com/providers/join-our-provider-network/provider-recruitment-form

Revalidation of Medical Assistance Providers

- All providers must revalidate their MA enrollment (including all associated service locations – 13 digits) every 5 years. Providers should log into PROMISe to check their revalidation date and submit a revalidation application at least 60 days prior.

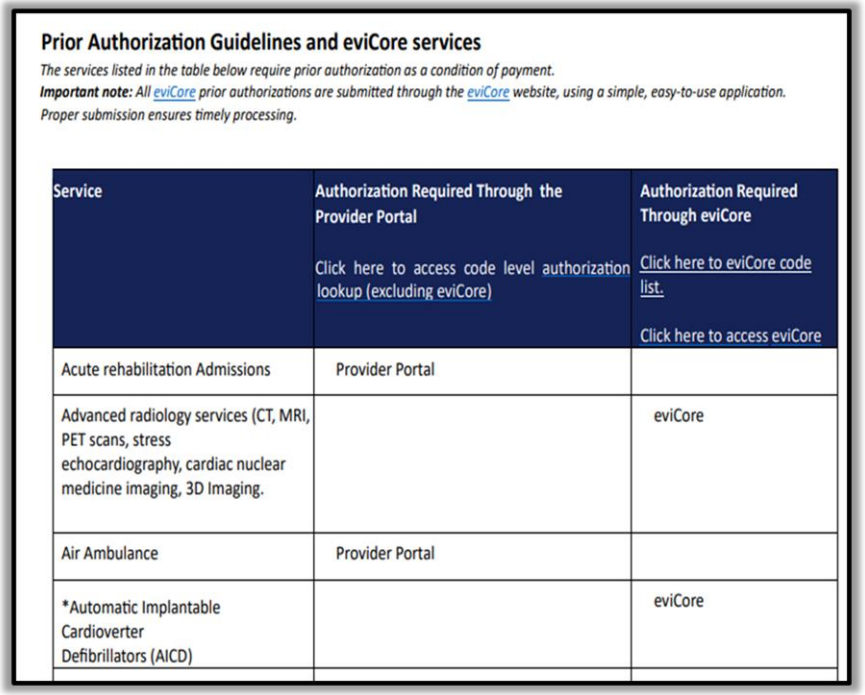
- Providers should check the Pennsylvania Department of Human Services (DHS) PROMISe system on a routine basis to confirm demographic data, including all service locations and revalidation dates to ensure information is current and have an active PROMISe ID. Please visit the DHS website for requirements and step-by-step instructions.

- Enrollment (revalidation) applications located at:
  - www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Utilization Management and Prior Authorization

Prior Authorization: Jefferson Health Plans and Evicore

- Prior authorizations are processed either through our **Provider Portal** or **eviCore**, depending on the type of service.
- Please refer to our **Prior Authorization Management Tool** to identify which services require submission through the Provider Portal or eviCore.



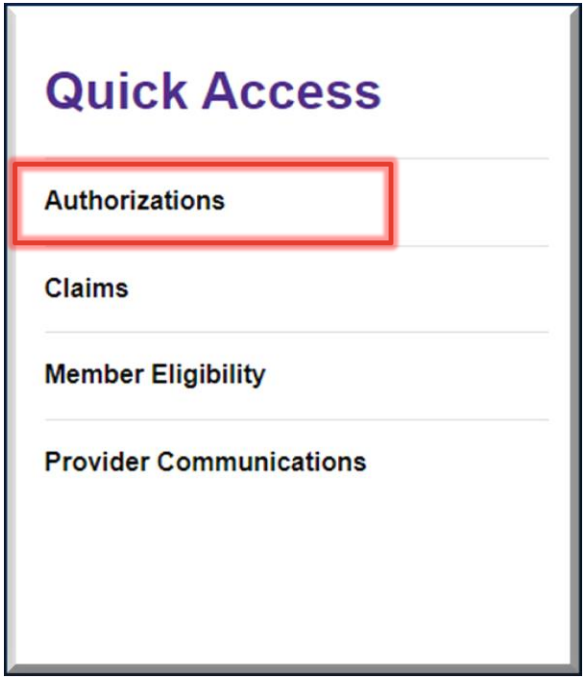
Prior Authorization Guidelines and eviCore services

The services listed in the table below require prior authorization as a condition of payment.
***Important note:** All eviCore prior authorizations are submitted through the eviCore website, using a simple, easy-to-use application. Proper submission ensures timely processing.*

Service	Authorization Required Through the Provider Portal Click here to access code level authorization lookup (excluding eviCore)	Authorization Required Through eviCore Click here to eviCore code list. Click here to access eviCore
Acute rehabilitation Admissions	Provider Portal	
Advanced radiology services (CT, MRI, PET scans, stress echocardiography, cardiac nuclear medicine imaging, 3D Imaging.		eviCore
Air Ambulance	Provider Portal	
*Automatic Implantable Cardioverter Defibrillators (AICD)		eviCore

Prior Authorization: Jefferson Health Plans

- Jefferson Health Plans requires *prior authorizations* for select services performed in an outpatient setting, including:
  - Those performed in-office
  - Short procedure units
  - Ambulatory surgery centers
  - Clinics
  - Hospital outpatient departments.



Prior Authorization Submission: Pharmacy

- There are specific medications on the formulary that require prior authorization.
- Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our Jefferson Health Prior Authorization webpage.
- To request a prior authorization, the physician or a member of his/her staff should contact **Jefferson Health Plans' Pharmacy department at 1-866-841-7659**, Monday through Friday, 8 a.m. to 6 p.m.
- Requests can also be *faxed* to **1-866-240-3712**.
- In the event of an *immediate need after business hours*, please call Member Relations at **1- 800-553-0784**. The call will be evaluated and routed to a clinical pharmacist on-call 24/7

Prior Authorization: Evicore

- Cardiology Studies/Procedures, Interventional Pain Management, Joint & Spine Surgery, Oncology, Advanced Radiology services, Sleep Management, or Therapy services (PT, OT and ST) require prior authorization through **eviCore**.

- Please visit our website for a current listing of all services that require authorization through eviCore, as well as direct access to the eviCore portal.
  - Prior Authorization Requirements (healthpartnersplans.com)

Utilization Management Ancillary Services and DME

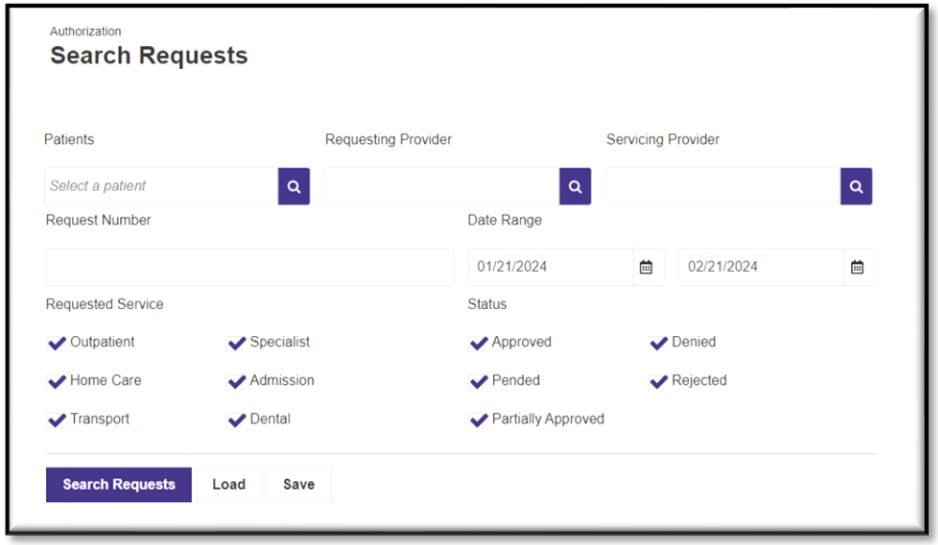
- Our UM department is committed to providing members with the most appropriate medical care for their specific situations.

- UM's decisions are based on medical necessity, appropriateness of care and service, the existence of coverage, and whether an item is medically necessary or considered a medical item.

- Jefferson Health Plans does not provide financial incentives for utilization management decision makers that encourage denials of coverage or service or decisions that result in under-utilization.
  - For more information, visit our Provider Manual Chapter 8: Utilization Management

Prior Authorization Process

- Providers should obtain prior authorization at least 7 days in advance for elective (non-emergent) procedures and services.
- Requests will be processed according to state and federal regulations.
- Failure to comply with this guideline may result in the delay of medically non-urgent services.



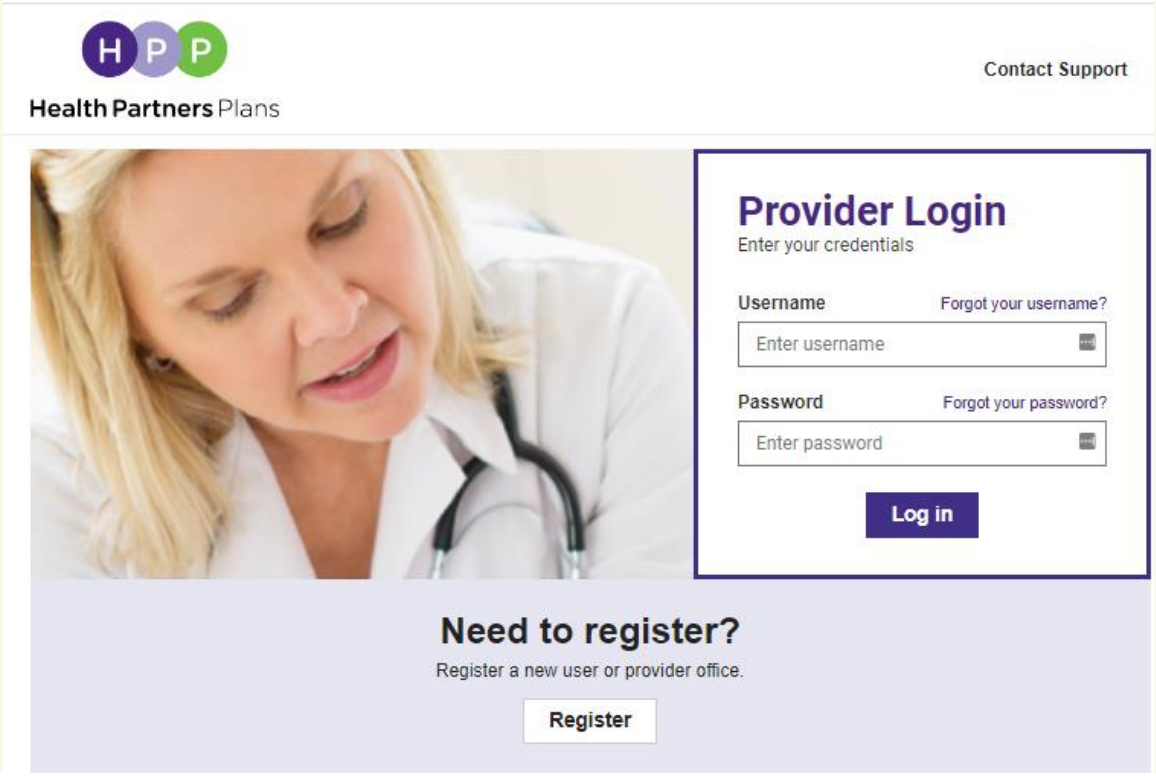
Prior Authorization Process cont.

- Providers may be contacted for discharge/transition planning for disenrolled members in some circumstances. Jefferson Health Plans will participate in this planning for up to **6 months** from the initial date of disenrollment, unless the member chooses a different plan.

- For elective admissions and transfers to non-participating facilities, PCP, referring specialist or hospital must call the **Jefferson Health Plans Inpatient Services Department** @ 1-866-500-4571.

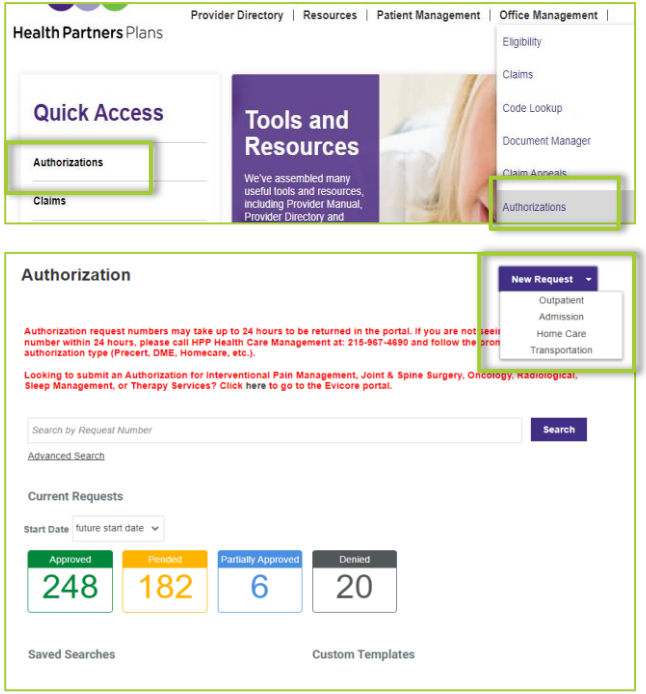
  - For more information, visit our Provider Manual Chapter 8: Utilization Management

Provider Portal- Prior Authorization Process



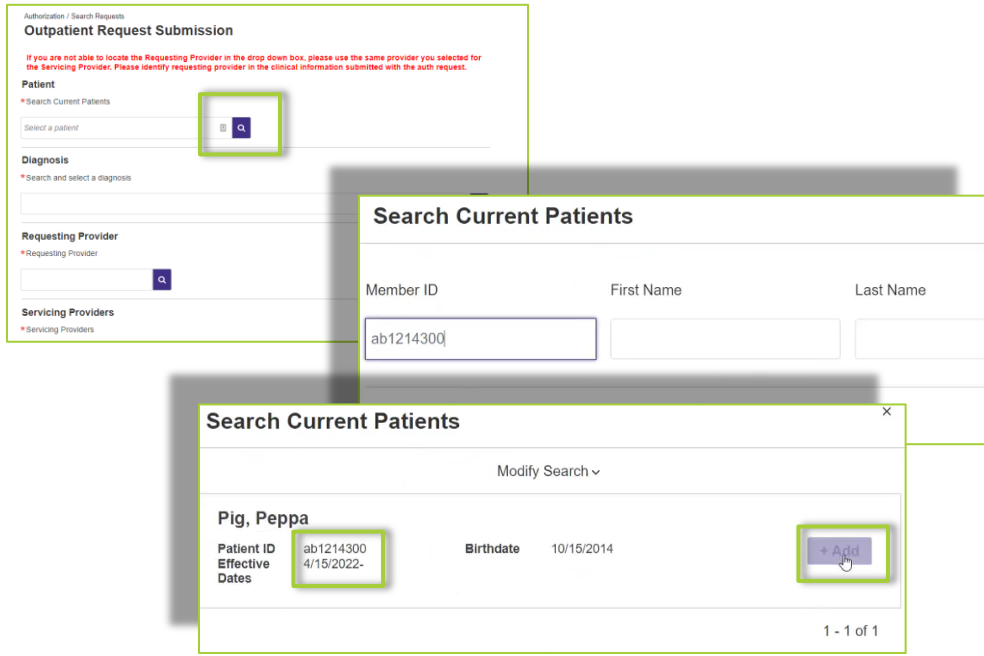
Provider Portal – Submitting Authorizations

1. Go to **HPPlans.com/ProviderPortal** to access Provider Portal Connect and log in.
2. From the Home screen, click Office Management > Authorizations or Quick Access > Authorizations.
3. The New Requests dropdown opens the Auth Submission dashboard.
   - Outpatient for DME, outpatient scheduled or elective procedures
   - Admission for acute care facility, hospital, or post-acute facilities
   - Home Care for home care services
   - Transportation request



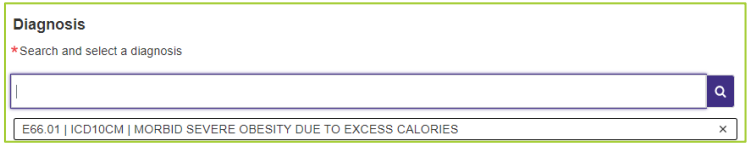
Provider Portal – Submitting Authorizations

4. **Start patient search** by clicking magnifying glass.
5. **Search Current Patients** by Member ID, First Name, Last Name
6. **Locate and add patient**
   - Make sure you select the appropriate patient from the search results.
   - Please make sure member has an active status for the dates of service. If not, you will receive an error during submission “The selected patient is not an eligible member as of the start date of this request”.



Provider Portal – Submitting Authorizations

7. **Diagnosis** is typically the diagnosis from the acute stay. Search for a diagnosis by entering ICD code or at least two characters and select one or more diagnosis codes.



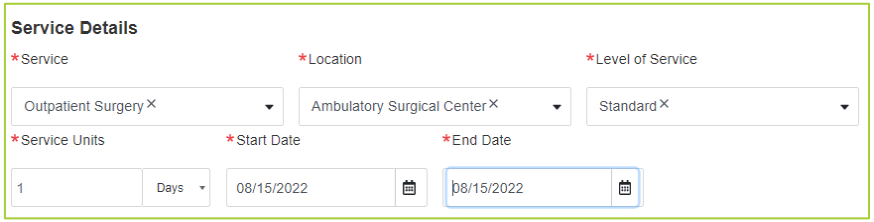
8. **Requesting Provider** is the provider/case manager from acute care facility requesting the service for patient. Search and select the requesting provider.

9. **Servicing Provider** is the facility that will be servicing the member. Search for a servicing provider by Last Name or Provider NPI, type, zip code, and/or specialty. You can also choose to include out of network providers by checking the box.

   Note: More than one servicing provider can be entered. For example, requests can require both servicing facility and servicing provider.

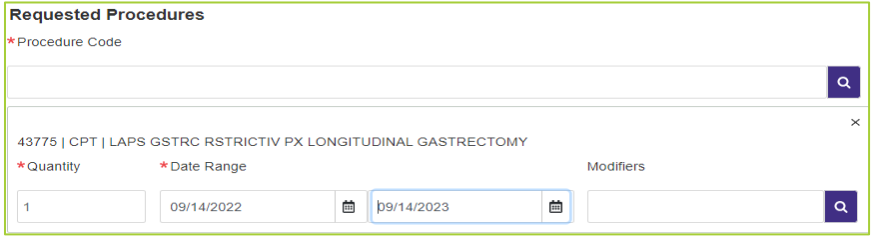
Provider Portal – Submitting Authorizations

10. **Service Details**
    - Service is the type of service
    - Location of the requesting facility.
    - Level of Service either Retrospective or Standard
    - Service Units is the duration of the request
    - Start Date and End Date for the event



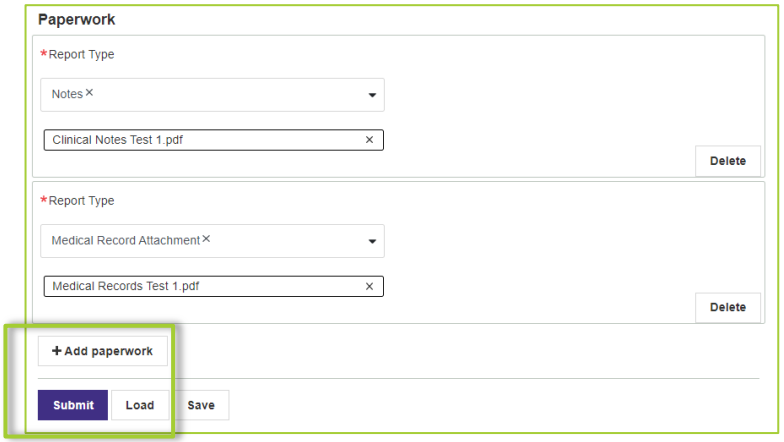
11. **Requested Procedures** search for a CPT, HCPCS or Revenue code for procedure code by entering numeric code or at least two characters and select one or more procedure codes.

    Procedure Code Information for each procedure, enter Quantity, Start Date and End Date.



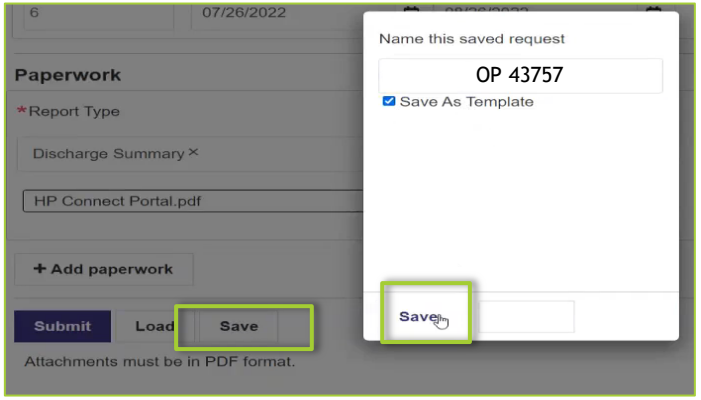
Provider Portal – Submitting Authorizations

12. **Paperwork** – add clinical documents
    a. Click “+ Add paperwork” and the new document line appears below.
    b. Click “Submit”



Provider Portal – Submitting Authorizations

- **Save Templates Requests**, providers can save the request to use the template for similar requests which appears in Custom template from the Dashboard.
  - Saves all fields, except dates of service and paperwork.
- A message appears in the upper right corner. This item has been successfully saved to your custom templates; except for dates of service and paperwork.

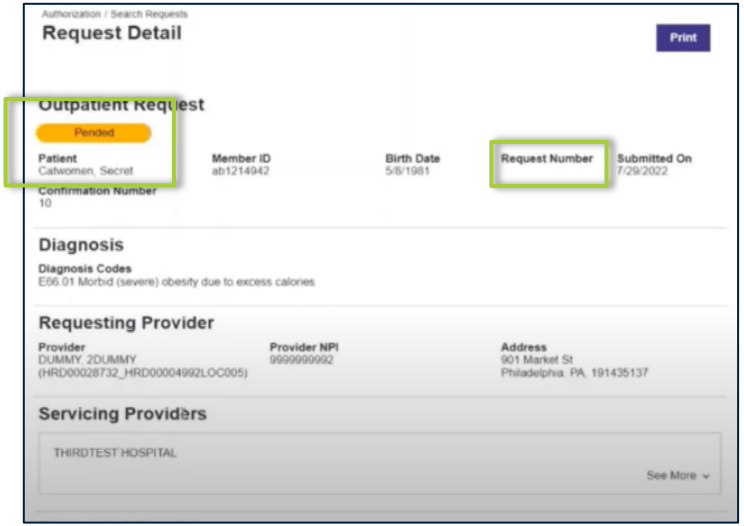


This item has been successfully saved to your Custom Templates list. Please note, attached files and service dates are not saved as part of custom template.

Provider Portal – Submitting Authorizations

Request Detail

13. Authorization Request Number may take up to 24 hours to be returned in the portal. If you are not seeing a request number within 24 hours, please call Jefferson Health Plans' Health Care Management at: 215-967-4690 and follow the prompts for your authorization type (Precert, DME, Homecare, etc.).

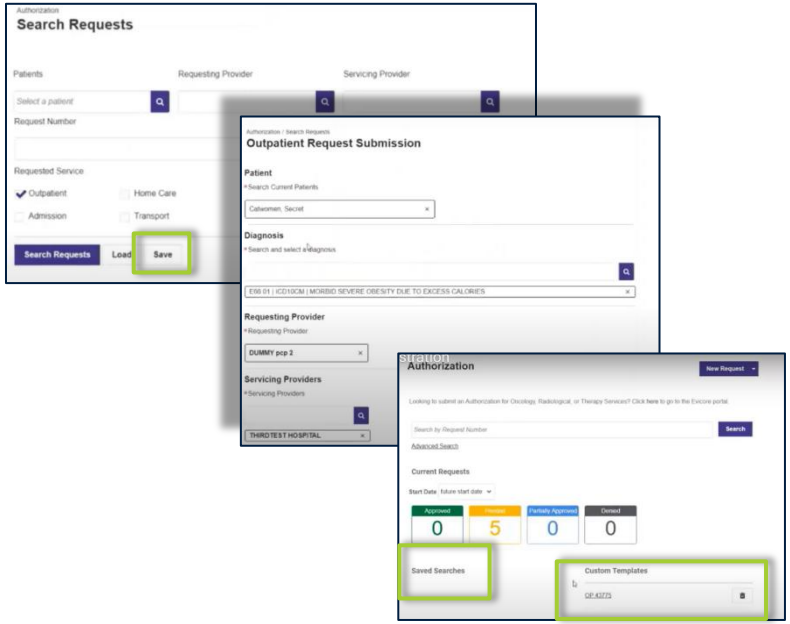


- The authorization number format includes 2 letters and a series of numbers.
  - Portal Outpatient - PO56464
  - Portal Inpatient - PI01010158476

Provider Portal – Submitting Authorizations

- **Advanced Search Request** screen the provider has the option to view the details of a specific request, or they can modify the search to return different results.
  - When you conduct a search, you have the option of saving the search criteria as a pre-defined, ‘favorite’ search.
  - With one click on saved search, search results are instantly returned using your saved search criteria.
- **Custom templates** must change member, dates and applicable paperwork.

- To watch a demonstration and learn more about Provider Portal authorization and claims process, please click here
  - View Claims – 19:35
  - Reconsideration – 25:05



Home Care

Home Care

- Home Health services include Skilled Nursing (RN, LPN), Home Health Aide (HHA), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Social Work (SW) visits.
- Requests must include a valid order for home health services and include supporting clinical documentation.
- Medicare Home Care servicing providers are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when ALL their Medicare covered service(s) are ending 48 hours prior to the termination of services. Please visit cms.gov for information.

Home Care Prior Authorization Requirements

- Home health agencies are encouraged to use the Provider Portal to submit all prior authorization requests.
- Providers have 5 business days from Initial start of care to submit requests to be considered timely.
- All ongoing homecare requests are expected to be submitted *before* services are rendered
- We make every attempt to provide determinations as quickly as possible when all required documentation is received timely
- Medicare has **14 days** to render a determination for all standard pre-service request.
- Medicaid has **2 business days** to render a determination for all standard pre-service requests.
- Medicaid has **30 calendar days** to render a determination on all retrospective requests.

Mandatory DHS and CMS Home Care Documentation Requirements

- **Orders** - Signed and dated (verbal) orders that include services dates/frequency
- **Referrals** - Signed and dated for the home care evaluation and/or start of care following a hospital or post-acute discharge
- **Clinical Discharge Summary -** from the inpatient stay
- **Visit notes** - (ongoing request)
  - Wound care notes
  - Therapy notes
- **Plan of care (485)** - Signed and dated by the overseeing provider in **30 days** of the start of care (SOC) and certification period

Home Care/ Home infusion Verbal Order

This impacts Health Partners (Medicaid), Medicare and KidzPartners members.

Mandatory DHS and CMS Home Care Verbal Order requirements:

- The orders must be signed and dated with the date of receipt.
- All verbal orders must have the name of the ordering/certifying practitioner along with the name and credential of the person taking the verbal order documented clearly.
- Verbal orders may be signed by a registered nurse, supervisor, or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker).
  - For Medicaid/CHIP, verbal order can be taken by a Registered Nurse, qualified therapist, or pharmacist(home infusion)

- For services furnished based on a physician or allowed practitioners* (MD, DO, NP, PA, CNS, Certified Midwife, DPM) orders, the orders may be accepted and put in writing by person authorized to do so by applicable state and federal laws and regulations.

- Verbal orders **must** be countersigned and dated by the physician or allowed practitioner (NP, PA, CNS, Certified Midwife) as soon as possible, but no later than **30 days**.

*Practitioners required to write prescriptions within their scope of practice

Home Care Order Requirements

DHS and CMS Home Care Order requirements:

- Signed orders are required by Health Partners Plans for all Home Health care service request.
- The Plan of Care will be clearly signed and dated within **30 days** of the Start of Care (SOC) and be submitted.
- Orders/certification is for the same services related to the diagnosis.
- New orders are required for new services or a change in diagnosis and management.

- **This constitutes a valid order:**
  - Obtained from a physician (MD, DO) or allowed practitioner *(NP, PA, CNS, Certified Midwife, DPM)
  - hospitalist referral, prescription, discharge instructions, plan of care/485, letter of medical necessity, electronic referral etc. A referral does not remove the requirement for the POC (485)
  - Written orders must have the date, time and credentials of the certifying practitioner

*Practitioners required to write prescriptions within their scope of practice

Home Infusion

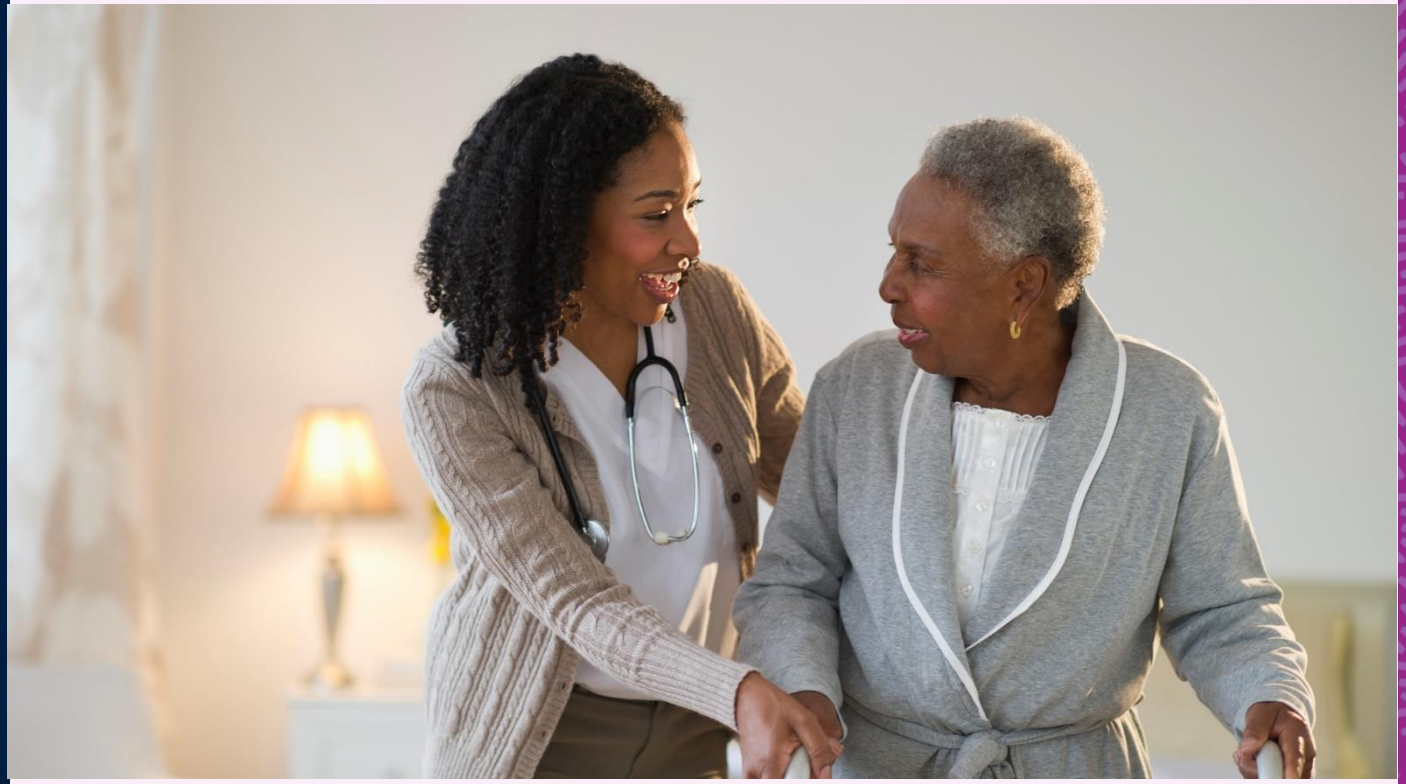
Home Infusion - Medicaid

- Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.
- Obtained from a physician (MD, DO) or practitioner (NP, PA, CNS, Certified Midwife, DPM)
  - Written orders must have the date, time and credentials of the certifying practitioner
- Prior Authorization is required for all Biologics, **nursing and supplies do not require authorization when services are performed by a par provider
- Non-par providers require prior authorization for home infusion Biologics, intravenous feedings, nursing and supplies.
- All requests are reviewed for Medical Necessity
- The frequency and duration of the administration of the medication must be within accepted standards of medical practice or must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.
- For home Chemotherapy, request can be submitted Evicore site or by calling 1-888-444-6178.
- Request can be submitted Provider Portal or Medicaid Ancillary fax 215-967-4491.

Home Infusions - Medicare Medical Part B

- Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.
- Prior Authorization is required for J and B codes; nursing and supplies do not require authorization when services are reasonable and necessary.
- Injectables (Home Infusion Therapy) are covered under the part D pharmacy benefit. For more information, please visit Prior Authorization.
- Where these services are reasonable and necessary the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, Must be a medical reason the medication cannot be taken orally.
- The frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.
- For home Chemotherapy, request can be submitted Evicore site or by calling 1-888-444-6178
- Infusion request can be sent to Provider Portal or Medicare ancillary fax 267-515-6633

Integra - Durable Medical Equipment (DME)



Integra - DME Medicaid & Medicare

DME Medicaid and Medicare requests must include:

- Complete signed order by certifying practitioner (NP, PA, DO, MD, CNM, DPM, etc.)
- Correct CPT/HCPC codes for all DME items requested with dates of service
- All request must include
  - DME provider name, NPI number of company supplying the equipment
  - Supplier Contact name and phone/fax number
  - Supporting clinical and signed orders
- DME requires prior authorization for all purchase items greater than $500 and all DME rentals
- Providers are highly encouraged to submit all standard DME requests provider portal.
  - As a last resort, please use the DME Authorization Request Form and fax to 215-849-4749 **(Medicaid)** or 267-515-6636 **(Medicare)**

Exclusive to Medicaid or Medicare:

- **Medicaid:** All miscellaneous codes require prior authorization
  - For more information, visit our website at Prior Authorization
- **Medicare:** A face-to-face is required when applicable per Medicare guidelines (e.g., oxygen recertification)

Mandatory DHS and CMS Oxygen Certification Requirements

- **Initial requests for Oxygen must include a complete signed order from MD/DO/Certifying Practitioner.**
- **A complete order consists of:**
  - Diagnosis code ICD10
  - Description of Equipment ordered CPT/HCPC code
  - Directions for Use of Equipment (e.g., flow rate, frequency)
  - Date of prescription/date of physician's signature
  - Signature AND printed name of physician prescriber
  - Physician's license number or NPI
  - Physician prescriber must be enrolled in PA Medicaid when the prescription was written
  - Provider printed information on the prescription must match the provider signature

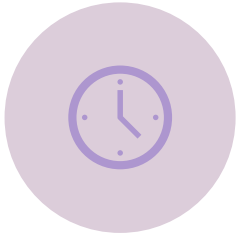
- ***Oxygen Certification Requirements***
  - The continued need for Oxygen must be certified every 6 months (Medicaid) or every 12 months for Medicare as applicable
  - Re-certification can be a prescription or a Certificate of Medical Necessity (if a prescription, must be complete)
  - A prescription is needed every year, in addition to the recertification requirement
  - Medicare requirements and criteria are based on NCD/Noridian LCD L33797
  - Medicare: A face-to-face is required when applicable per Medicare guidelines.

Shift Care (Skilled Nursing, Home Health Aide Services, Medical Day Care)

Shift Care/Medical Day Care

Requests submitted via provider portal or fax to 267-515-6667 (Shift Care Authorization Form)

Letter of medical necessity (LOMN) is signed and dated, and is required from certifying practitioners (NP, PA, DO, MD, CNM, DPM, etc.)



Specific number of hours per day/week/duration

Work verification if hours are being requested for the legally responsible relative to attend work

Electronic Visit Verification (EVV): HHAeXchange

- HHAeXchange is the EVV vendor for Jefferson Health Plans.
- EVV is required for all shift care home health aide visits. Starting January 1, 2024, EVV will be required for ALL home health visits.
- Providers have **60 days** to accept members in HHAeXchange once authorization is approved.
- Providers are required to report all missed shifts weekly to Jefferson Health Plans.
- For assistance with HHAeXchange, email **support@hhaexchange.com**.

Electronic Visit Verification (EVV): Verification Points

Regarding EVV, claims will be rejected if they fail to meet one of the 6 required verification points below.

1. The type of service provided
2. The name of the individual receiving the services
3. The date of service delivery
4. The location of service delivery
5. The name of the individual providing the service
6. The time the service begins and ends

HHAeXchange

- Contact HHAeXchange for claims submission related issues and assistance with setting up an account.
- Providers have **60 days** from the authorization approval date to accept the member in the portal.
- If the provider has multiple locations, be sure to accept the member into correct location that will be servicing and later submitting a claim for the member.
- Allow **24 hours** for an approved authorization to appear in the HHAeXchange portal.
- For claims EOP disputes, please contact Jefferson Health Plans' Provider Services Helpline at 1-888-991-9023.

Non-Emergent Transportation

Behavioral Health Non-Emergent Transportation Medicaid, Medicare & CHIP

Behavioral health non-emergent (stretcher) transportation does not require prior authorization for all lines of business.

Health Partners (Medicaid) ambulance providers must have an active PROMISe ID# and all claims must include a behavioral health ICD-10 diagnosis code.

All behavioral health transports must be for a level of transport appropriate to the documented need for a Jefferson Health Plans member to a behavioral health facility.

Non-Emergent Transportation

Medicaid

Prior authorization is **not** required for Non-Emergent transportation requests from a par or non par provider.

Medicare

Prior authorization is **required** for Non-Emergent transportation requests from a par provider.

CHIP

Not a covered benefit

Home Health Services and Non-Emergent Transportation Facsimile

Home Care and Home Infusion	Fax: 267-515-6633 (Medicare)
	Fax: 215-967-4491 (Medicaid)
Durable Medical Equipment (DME)	Fax: 267-515-6636 (Medicare)
	Fax: 215-849-4749 (Medicaid)
Shift Care/Medical Daycare	Fax: 267-515-6667
Non-emergent Transport	Fax: 267-515-6627

Skilled Nursing Facility/ Pediatric Skilled Nursing Facility

Skilled Nursing Facility - Medicare

- Prior authorization for post-acute skilled nursing admissions is required.
- All eligible Jefferson Health Plans Medicare members must meet CMS guidelines and evidence based clinical criteria.
- All request are subject to a secondary review by a Medical Director.
- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- The documentation must be submitted timely with clinical and therapy clinical within 48 hours of request. The requested services are appropriate in terms of duration, quantity, and that the services promote the documented therapeutic goals.
- Medicare does not have a custodial care benefit; **however**, dual enrolled (DSNP) members may be eligible under their secondary payer (Medicaid CHC).

Skilled Nursing Facility – Medicare continued

- Medicare covers **100 days** of SNF per episode. Please refer to Medicare General information, Eligibility, and Entitlement Manual chapter 3 sect 10.4.1 for information.

- SNFs are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending 48 hours prior to the termination of services. The NOMNC informs beneficiaries on how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives beneficiaries the opportunity to request an expedited determination from a BFCC-QIO. A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of covered services.

- Jefferson Health Plans uses the product's specific definition of medical necessity, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and available InterQual® criteria as documented in the Subacute and SNF modules.

Skilled Nursing Facility - Medicaid

- Prior authorization for post-acute skilled nursing admissions is required.
- There must be an accepting facility prior to submitting the request or else the auth will not be processed.
- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- The documentation must be submitted timely and show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

Skilled Nursing Facility – Medicaid continued

- Medicaid has a bed hold benefit. The benefit provides a 15-day bed hold per hospital confinement. An authorization is required for payment. If Jefferson Health Plans isn't notified of a need for a bed hold, those days will be denied.

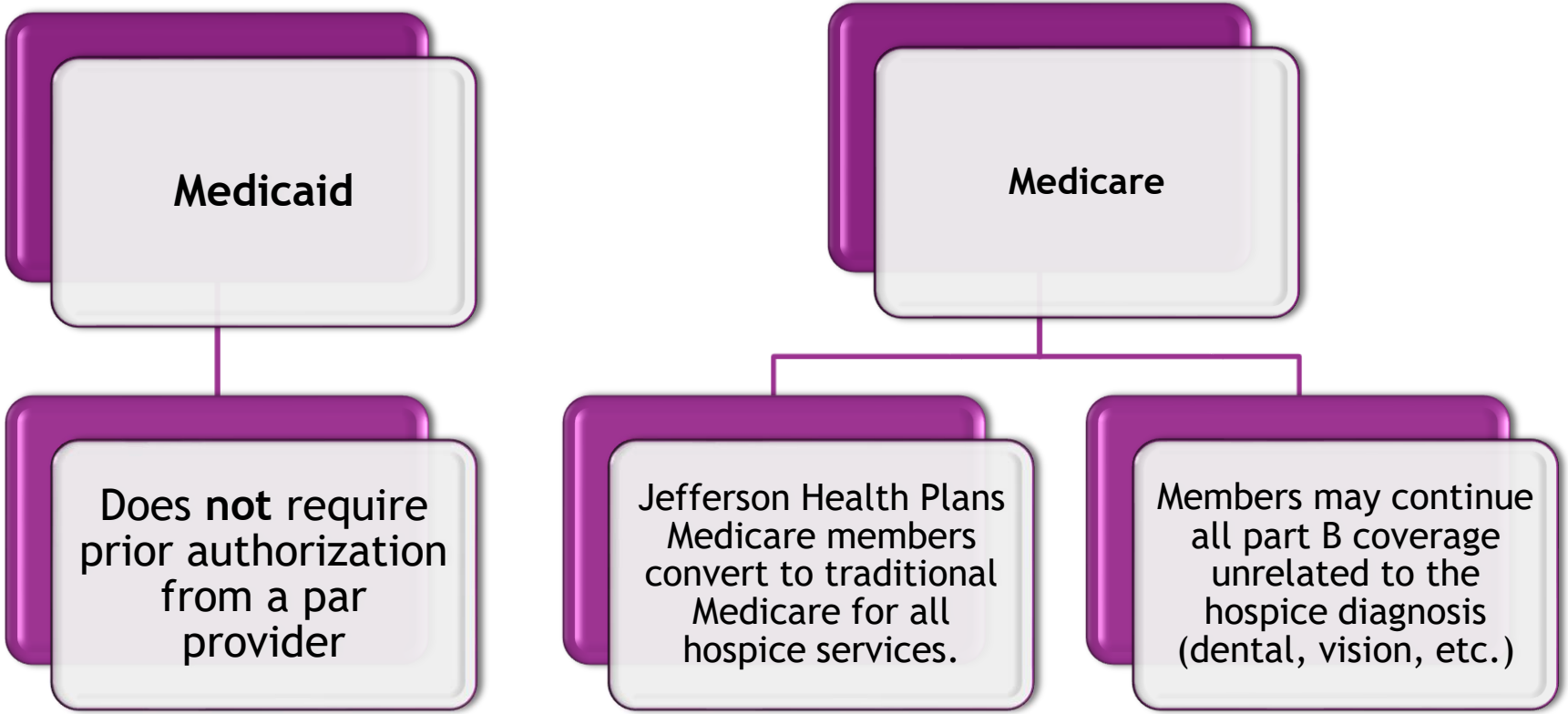
- Medicaid has a 30-day custodial benefit and authorization is required for payment.

- There is no more 30-day disenrollment.
  - If member is applying for LTSS (CHC) proof of application is required. Auth will be reviewed for medical necessity, even beyond 30 days of skilled confinement. Once downgraded to custodial level of care, the 30 days will be given up front. If a CHC start date is not available on day 31, the auth will be put in CHC pended status until a start date is obtained. Once a start date is received, the auth will be updated to pay all remaining days.

- Jefferson Health Plans uses the product's specific definition of medical necessity, National Coverage Determinations(NCDs), Local Coverage Determinations (LCDs)and available Inter Qual® criteria as guidelines for the review and decision making based on the 2022 InterQual criteria in the Subacute and SNF modules.

Home and Inpatient Hospice

Home Hospice



Inpatient Hospice

- Inpatient Hospice is a benefit for all Medicaid Members.
  - A member qualifies for inpatient hospice if they are actively dying or require treatment that can't be managed in the home.

- <u>Documents required for a pre-certification of a hospice admission are:</u>
  - Signed Hospice Election Form
  - Signed Certificate of Terminal Illness.
  - Plan of care
  - Current assessment of the members condition/symptoms
    - What are the current exacerbating symptoms and interventions?
    - When did they start occurring?
    - Why is member unable to be managed at home?
    - Who is the members support network?

Inpatient Hospice Review Process

- Every inpatient hospice case will be reviewed for medical necessity by Jefferson Health Plans Medical Directors.
- All inpatient hospice requests must be submitted with the required signed documentation before a medical necessity review is completed.
- If approved for inpatient level of care (LOC), 5 days will be approved.
- If the initial request or continued stay request is deemed not medically necessary, the request will be downgraded and be paid at a home hospice level of care.
- Appeal and P2P options will be available.

PA Medicaid Regulations and Codes

- Jefferson Health Plans must be notified when members begin to receive hospice care, and when they end their hospice care.
- Outpatient Hospice providers must educate members about the services which are included in Hospice care, and that the member should not obtain these services from other providers while enrolled in Hospice care. It is best practice to obtain and maintain a signed copy of this education in your records.
- Jefferson Health Plans follows the PA Medicaid regulations/codes in regards to the requirements of hospice care, please refer to the below.
  - Refer to 55 Pa. Code § 1101(General Provisions), 55 Pa. Code § 1130 (Hospice Services) and § 1101 (General Provisions), MA Bulletins, and the State Operations Manual Appendix M-Guidance to Surveyors: Hospice, and the Hospice Services Handbook. Please note that Levels of Care needs must be documented as well and that some services can only be provided when the member nears the end of life. he requirements of hospice care, please refer to the below.

Ambulatory Surgical Center

Ambulatory Surgical Center

- All services performed in an outpatient location that require Prior Authorization can be located at Prior Authorization.
- Please request services utilizing the Jefferson Health Plans Provider Portal.
- Services should be requested at least three weeks prior to scheduled procedure.
- Authorizations for services approved will remain open for **3 months**, except organ transplants request which will remain open for **1 year**.

Complaints, Grievances and Appeals

Complaints, Grievances and Appeals

- When Jefferson Health Plans denies, decreases, or approves a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, healthcare provider or other member's representative (with the appropriate written consent of the member) to request that Jefferson Health Plans reconsider its decision.
- In some cases, a member can ask DHS to hold a "fair hearing" because they disagree with a Jefferson Health Plans' decision. A member must exhaust Jefferson Health Plans' Complaint or Grievance Process before they request a Fair Hearing.

  - For more information, visit
    - Health Partners (Medicaid) Member Handbook
    - For more information, visit our Provider Manual Chapter 13: Complaints, Grievances, and Appeals or eLearning course, Complaints, Grievances and Medical Necessity Reviews: Learn The Process or call Provider Services Helpline at 1-888-991-9023.

Cultural and Linguistic Requirements and Services

Cultural and Linguistic Requirements and Services

- Cultural Competency is one of the main ingredients in closing the disparities gap in health care.
- It requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor's office by virtue of their heritage.

Cultural and Linguistic Requirements for members with Limited English Proficiency (LEP)

- Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location, at the providers cost.
    - If you need assistance our helpline can assist providers in locating services for members who need a qualified interpreter present at an appointment or telephonically. Please contact our Provider Services Helpline at 1-888-991-9023.

A Physician's Practical Guide to Culturally Competent Care is sponsored by DHHS Office of Minority Health. This is a free, self-directed training course for physicians and other health care professionals.

- This is a recommended web site that offers CME/CE credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve.

cccm.thinkculturalhealth.hhs.gov

Fraud, Waste and Abuse (FWA)

FWA False Claims Act

- The False Claims Act is the most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including providers, every year.

- Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages, plus civil penalties. DOJ has increased False Claims Act (FCA) penalties to $11,665 - $23,331 per false claim, effective June 2020.

- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at 1-866-477-4848.

FWA False Billing & Procedural Neglect

- False Billing
  - Services already paid for or never rendered
  - Upcoding: Billing to increase revenue instead of billing to reflect actual work performed
  - Unbundling: Billing for each procedure separately instead of using grouping that is to be billed together
  - Forging physician signatures when such signatures are required for obtaining reimbursement

- Procedural Neglect
  - Perform medically unnecessary procedures
  - Falsified diagnoses to justify additional tests or overstated treatments

MA Provider Self-Audit Protocol

- The DHS Medical Assistance Provider Self-Audit Protocol allows providers to disclose any overpayments or improper payments:
  - 100 Percent Claim Review
  - Provider-Developed Audit Work Plan for BPI Approval

- Intended for MA providers that participate in both the fee-for-service and managed care environments.

- The protocol provides guidance to providers on the preferred methodology to return inappropriate payments to DHS.

- Providers also have the option for conducting an audit via the DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SRVS)

Provider Screening and Enrollment

- Under the regulations of 42 CFR § 455.436, Jefferson Health Plans is required upon enrollment and monthly thereafter to check the exclusions status of our providers on the following "U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG)" data bases:
  - List of Excluded Individuals and Entities (LEIE)
  - Excluded Parties List System (EPLS)

- Additionally, State requirements include Medicheck screening.

- In-network providers are also responsible for conducting the same above screen process for their owners, staff, subcontractors/downstreams and report upwards any true matches.

- Screening against all exclusion databases must be done both prior to hire/contracting and monthly thereafter. Providers should maintain documentation of the screenings and results, and should notify Jefferson Health Plans immediately, should anyone be identified on one of these exclusion sites.

Complete Your Attestation

Thank you for your participation in the Jefferson Health Plans provider network and for your commitment to our member's health care needs!

Attestation:

- Please complete the provider education attestation by accessing the following link:
  - https://www.healthpartnersplans.com/providers/provider-education-attestation?tot=Orientation

Questions

Please use the Q&A panel for all questions.

For any additional questions that may arise, please email: providercommunications@jeffersonhealthplans.com

Upcoming webinars: Register at https://www.healthpartnersplans.com/providers/training-and-education/webinars

Webinar Title	Date	Time
Quality Initiatives, Opportunities and Resources	Wednesday, April 10, 2024	12:00
Care Coordination Support for You and Your Patients	Wednesday, June 5, 2024	12:30

Plan Contacts and Resources

Provider Services Helpline 888-991-9023 9:00-5:30 pm	Medical Providers	Prompt 1
	Pharmacies	Prompt 2
	Join our Provider Network	Prompt 3
	Member Services	Prompt 4
Additional Resources	Utilization Management	866-500-4571
	Care Coordination	215-845-4797
	eviCore Radiology auths, PT/OT/ST and other expanded services	888-693-3211
	ECHO Health – electronic funds transfer and remittance advice	888-834-3511
	Quality Management	855-218-2314
	Skilled Nursing Facilities and Rehabilitation	215-991-4395 (MC) 267-385-3825 (MA) Fax: 215-991-4125
	KidzPartners (CHIP) Magellan Behavioral Health	800-424-3702
	Health Partners Medicare Magellan Behavioral Health	800-424-3706

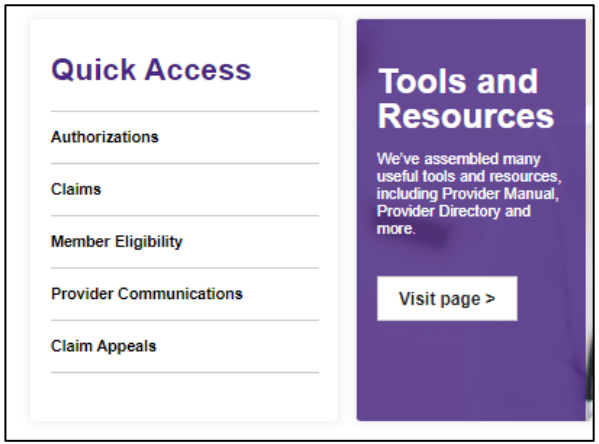
Plan Contacts and Resources

Providers	JeffersonHealthPlans.com/providers
Provider Manual	Healthpartnersplans.com/providermanual
Provider Portal	Healthpartnersplans.com/hp-connect
Training & Education	Healthpartnersplans.com/training
Provider Directories	Healthpartnersplans.com/directory
Formularies	Healthpartnersplans.com/formulary
ECHO Health	https://www.echohealthinc.com
Claims	Healthpartnersplans.com/claims
Contracting	Contracting@jeffersonhealthplans.com

Provider Relations

Provider Relations relies on multiple ways of communications to reach our provider network.

- Webinars
- Fax Blasts
- Provider Portal
- Provider Newsletter
- Training & Education
- Provider Relations Representatives
- Provider Portal Provider Communications
- Provider Communication Education Specialists



Thank you for joining us today!

Jefferson Health Plans

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Appendix

Additional Content

- Provider Portal- slide 17 -19
- Coordination of Benefits – slide 29
- Special (HMO SNP) Plan Reminders – slide 34
- Prior Authorization Process slides 44-54
- Oxygen Certification Requirements – slide 66
- Home Health Services and Non-Emergent Transportation Facsimile - slide 75
- Skilled Nursing Facility – slide 80
- FWA False Billing & Procedural Neglect – slide 96
- Appendix/ Additional Plan Contacts and Resources – slides 102-106