Keystone First

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Important Plan Telephone Numbers: updated phone and fax numbers, as appropriate.	16-17 and throughout manual
Definitions: updated definitions, as appropriate.	18-30
Referral & Authorization Requirements	
Services that require prior authorization: Added "Program Exception Process" to Any service/product not listed on the Medical Assistance fee schedule or services or equipment in excess of limitations set forth by the Department of Human Services fee schedule, benefit limits, and regulation. (Regardless of cost, i.e., above or below the $750 DME threshold).	45
Prior Authorization Lookup tool: Added "Prior Authorization through NaviNet" section	47
Dental Benefits for Children under the age of 21: updated age of children less than twenty-one years old and up to six times per year for fluoride varnish treatment	53
Dental Benefits for Members age 21 and older: added asterisks on check-ups and cleanings to show that Benefit Limit Exceptions applies. Language added that exceptions may apply if services are requested more frequently than every 180 days.	52-53
Sterilization and Hysterectomies: added that consent for can either be submitted electronically via Change Healthcare attachments (275 transactions) or mailed to appropriate address.	66-67 & 69
Nursing Facility Covered Services: language added for days from the 31st day forward, the UM department will review Skilled Nursing Facility admissions based on medical necessity review.	73 & 119
Family and Medical History for EPSDT Screens – Dental Screening: removed language for completing a dental referral for all children age three and above.	85-86
Radiology Services: updated National Imaging Associates, Inc. (NIA) to their new name, Evolent Specialty Services, Inc. (Evolent)	105-106
Provider Services	
NaviNet Supports Back Office Functions: changed Intensive Case Management Reimbursement Program to Condition Optimization Program.	125
Provider Network Management: added language clarifying the provider change form must be submitted at least 30 days prior to the effective date of the change.	128
Primary Care Provider (PCP) & Specialist Office Standards & Requirements	
Responsibilities of All Providers: added notice of nondiscrimination and the taglines must be posted in physical locations where Providers interact with the public and attending at least one Provider education training session conducted by the Plan.	132
Vaccines for Children Program: updated Division of Immunizations to Bureau of Communicable Diseases and email address.	136
Additional Requirements of PCPs: added when a PCP is notified that a Member is transferring or selecting a new PCP, the PCP should forward the Member's medical record to the new Primary Care network.	142

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Transfer of Non-Compliant Members: added Panel Transfer Coordinator fax number for written requests.	144
Payment in Full: added additional language regarding providers treating a dually eligible recipient.	148-149
Claims	
The Federal False Claims Act: updated cost of civil penalties	165
Reporting and Preventing Fraud, Waste and Abuse (FWA): updated Special Investigations Unit address	168
Provider Dispute/Appeal Procedures; Member Complaints, Grievances, and Fair Hearings	
What is a Complaint? Updated to reflect Member definition.	179
Member Complaints, Grievances and Fair Hearings: Updated all "What to do to continue getting services" in this section. Member has 15 days to respond to continue current services during this process (previously 10 days).	183-194
Quality Assessment Performance Improvement, Credentialing, and Utilization Management	
Timeliness of Utilization Management Decisions: Table 1 – added Home Health, Non-Urgent Precertification.	220
Special Needs & Care Management	
Care Coordination and Special Needs Unit: updated transportation needs to social determinants of health.	225
Member Support through Community Based Care Management (CBCM) programs, Case Management (CM), and Community Health Workers (CHW): added new section	229-230
Tobacco Cessation: revised section	231