

Section II Referral & Authorization Requirements



Referral Requirements

When a PCP determines the need for medical services or treatment, which will be provided outside the office, he/she must approve and/or arrange referrals to a participating Specialist, hospital or other outpatient facility. Although specialty services will not require a referral form, Keystone First expects that primary care and specialty care physicians will continue to follow and engage in a coordination of care process, in accordance with applicable laws, that includes communication and sharing of information regarding findings and proposed treatments.

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

Services Requiring a Referral:

- Initial visits to a Specialist*/hospital or other outpatient facility

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

- Prenatal OB visits
- Routine OB/GYN visits
- Routine Family Planning Services
- Members may go to any doctor or clinic of their choice to obtain Family Planning Services
- Routine Eye Exams **
- Prescription eyeglasses for Members under 21 years of age
- Routine Dental Services ***
- Tobacco Cessation Counseling
- Emergency Services including emergency transportation
- Behavioral Health, Drug and Alcohol treatment (a list of Behavioral Health Providers is located in this Section of the Manual)
- Initial Chiropractic Visit/Evaluation
- The following Diagnostic Tests performed on an outpatient basis with a prescription: Routine Mammograms, Chest X-rays, Ultrasounds, Non-Stress Tests, Pulmonary Function Tests (Please refer to the Prior Authorization list in this section of the Manual for a list of radiological procedures that require Prior Authorization)
- Pre-Admission Testing and Stat Lab Services
- Diagnostic Tests and Procedures performed in a Short Procedure Unit, Ambulatory Surgery Center or Operating Room****
- Routine lab work with a prescription
- DME Purchases less than \$750 if on MA Fee Schedule and with a prescription

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

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- ** Some Specialty Eye Care Services may require a referral. See "**Ophthalmology Services**" in this Section in the Manual.
- *** Some Dental Services may require a Benefit Limit Exception.. See "**Dental Services**" in this section of the Manual.
- **** A referral is not necessary but Prior Authorization is required for the following:
 - Steroid injections or blocks administered for pain management
 - Gastroplasty
 - Ligation and Stripping of Veins
 - All non-emergent plastic or cosmetic procedures, other than those immediately following traumatic injury, including ***but not limited to***, the following:
 - Blepharoplasty
 - Reduction Mammoplasty
 - Rhinoplasty

Referral Process

When a PCP determines the need for medical services or treatment, which occurs outside the office, he/she must approve and/or arrange referrals to a participating Specialist, hospital or other outpatient facility.

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

The PCP's office should:

- Verify Member eligibility
- Determine if the needed service requires a referral or Prior Authorization from Keystone First (See "Services Requiring Referrals and Prior Authorization" in this section of the Manual)
- Select a participating Specialist/ hospital or other outpatient facility appropriate for the Member's medical needs from the Specialist Directory, as appropriate. There is also an online Network Provider Directory with search capability at <http://www.keystonefirstpa.com/>. (If an appropriate Network Provider is not listed in the Network Provider Directory please call Provider Services **1-800-521-6007** for assistance. See "**Out-of-Plan Referrals**" in this Section for additional information.)

How to refer a member to a participating Keystone First specialist:

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

- Member name and ID number.
- Reason for referral.
- Duration of care to be provided.
- All relevant medical information.
- Referring practitioner's name and Keystone First ID number.

The Specialist office should:

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

Approval of Additional Procedures

Additional Procedures Performed in the Specialist Office or Outpatient Hospital/Facility Setting

When a Specialist determines that additional diagnostic or treatment procedures are required during an office visit, the Specialist must first determine if the procedures require further Prior Authorization. See "**Prior Authorization Requirements**" in this section of the Manual.

If the procedure/treatment does require Prior Authorization, call the Utilization Management Department **1-800-521-6622** for Prior Authorization. It is not necessary that the Specialist or Member re-contact the PCP office, however, the Specialist's office should inform the PCP of all diagnostic procedures, diagnostic tests and follow-up care prescribed for the Member.

Additional Procedures Requiring Inpatient or SPU Admission

When the Specialist determines that additional medical or surgical procedures require an inpatient or SPU admission, the Specialist must first determine if the procedures require further Prior Authorization. See "**Prior Authorization Requirements**" in this section of the Manual. When a procedure does require Prior Authorization, the Specialist should contact Keystone First Utilization Management Department at **1-800-521-6622** to obtain Prior Authorization. The admission will be reviewed for medical necessity and a case reference number will be assigned. Pre-approval for medical/surgical admissions may be requested directly by the attending specialist. It is not necessary that the Primary Care Practitioner (PCP) be contacted first, however, Keystone First requires Specialists to maintain contact with the referring PCP regarding the Member's status. Specialists should provide timely communication back to the member's PCP regarding consultations, diagnostic procedures, test results, treatment plan and required follow up care.

Follow-Up Specialty Office Visits

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

The Specialist office should:

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

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

Out-of-Plan Referrals

Occasionally, a Member's needs cannot be provided through the Keystone First Network. When the need for "out-of-plan" services arises, the Network Provider should contact the Utilization Management Department. The Utilization Management Department will make arrangements for the Member to receive the necessary medical services with a Specialist of Keystone First's choice in collaboration with the recommendations of the PCP. Every effort will be made to locate a Specialist within easy access to the Member.

Keystone First's Utilization Management Department Telephone Number is **1-800-521-6622**.

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

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

Enroll by visiting: <http://provider.enrollment.dpw.state.pa.us/>

Standing Referrals

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

Referrals/Second Opinions

Second opinions, or consultations, may be requested by a Member, the PCP, or Keystone First itself. These services require a referral from the PCP. For more information, see the "**Referral Process**" in this section of this Manual for direction.

With respect to second opinion consultations, the following is highly recommended by Keystone First:

- The selected consulting Network Provider should be in a practice other than that of the attending Network Provider
- The selected consulting Network Provider should possess a different tax identification number than the attending Network Provider
- The selected consulting Network Provider should possess a similar medical degree or medical specialty in order to provide an unbiased, but informed medical opinion on the condition for which the consultation is being requested

Prior Authorization Requirements

The most up to date listing of services requiring Prior Authorization can be found in the Provider Center at www.keystonefirstpa.com in the Provider Reference Guide or in posted updates.

Services Requiring Prior Authorization*:

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



1. All elective (scheduled) inpatient hospital admissions, medical and surgical including rehabilitation
2. All elective transplant evaluations and procedures
3. Elective/non-emergent Air Ambulance Transportation
4. All elective transfers for inpatient and/or outpatient services between acute care facilities
5. Skilled Nursing facility admission for alternate levels of care in a facility, either free-standing or part of a hospital, that accepts patients in need of skilled level rehabilitation and/or medical care that is of lesser intensity than that received in a hospital, not to include long term care placements
6. Gastroenterology services (codes 91110 and 91111 only)
7. Bariatric surgery
8. Pain management services performed in a short procedure unit (SPU) or ambulatory surgery unit (either hospital-based or free-standing) and pain management services not on the Medical Assistance fee schedule performed in a physician's office.
9. Cosmetic procedures regardless of treatment setting to include, but not limited to the following: reduction mammoplasty, gastroplasty, ligation and stripping of veins and rhinoplasty
10. Outpatient Therapy Services (physical, occupational, speech)
 - Prior authorization is not required for an evaluation and up to 24 visits per discipline within a calendar year
 - Prior authorization is required for services exceeding 24 visits per discipline within a calendar year
11. Cardiac and Pulmonary Rehabilitation
12. Chiropractic services after the initial visit
13. Home Health Services
 - Prior authorization is not required for up to 6 home visits per modality per calendar year including: skilled nursing visits by a RN or LPN; Home Health Aide visits; Physical Therapy; Occupational Therapy and Speech Therapy
 - The duration of services may not exceed a 60 day period. The member must be re-evaluated every 60 days
 - All Shiftcare/Private Duty Nursing services, including services performed at a medical daycare or Prescribed Pediatric Extended Care Center
 - Injectables
 - Home Sleep Study
14. DME
 - Purchase of all items in excess of \$750
 - DME monthly rental items regardless of the per month cost/charge

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- The purchase of all wheelchairs (motorized and manual) and all wheelchair items (components) regardless of cost per item
- The rental of all wheelchairs (motorized and manual) and all wheelchair items (components) regardless of cost per item

Enterals:

- Prior authorization is required for members over the age of 21
- Prior authorization is required when the request is in excess of \$350/month for members under the age of 21

Diapers/Pull-ups:

- Any request in excess of 300 a month for diapers or pull-ups or a combination of both.
- Requests for brand specific diapers.
- All requests for diapers supplied by a DME provider, other than J&B Medical Supply, Bright Medical Supply, King of Prussia Pharmacy, or Matts Pharmacy & Medical Supply (refer to the Durable Medical Equipment section for complete details)

15. Any service(s) performed by non-participating or non-contracted practitioners or providers, unless the service is an emergency service

16. All services that may be considered experimental and/or investigational

17. Neurological Psychological Testing

18. Genetic Laboratory Testing

19. All miscellaneous/unlisted or not otherwise specified codes

20. 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 \$500 DME threshold)

21. Ambulance Transportation to and from Prescribed Pediatric Extended Care Center

PPECC/Medical Daycares Guidelines:

- Member under 21 years of age
- Member approved for services at a PPECC/Medical Daycare
- Member requires intermittent or continuous oxygen, ventilator support and/or critical physiologic monitoring or critical medication(s) during transport requiring ambulance level of care
- There are no existing mechanisms for caregivers to transport the member
- Request for ambulance services are prior authorized along with initial request for PPECC/Medical Daycare services, with each re-authorization of Medical Daycare services, and/or when there is a change in level of care regarding oxygen, ventilator support and/or specific medical treatment during transport
- Member Services Transportation Department will be notified with each ambulance approval to initiate and/or continue ambulance transport services

22. Radiology - The following services, when performed as an outpatient service, requires prior authorization by Keystone First's radiology benefits vendor. Refer to the Radiology Services section for prior authorization details.

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

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

23. Select prescription medications. For information on which prescription drugs require authorization, the Keystone First Formulary can be found in the Provider Center at www.keystonefirstpa.com

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

25. Elective termination of pregnancy – Refer to the Termination of Pregnancy section for complete details.

*Prior authorization is not a guarantee of payment for the service(s) authorized. Keystone First reserves the right to adjust any payment made following a review of the medical record and determination of medical necessity of the services provided.

Members with Medicare coverage may go to Medicare Health Care Providers of choice for Medicare covered services, whether or not the Medicare Health Care Provider has complied with Keystone First's Prior Authorization requirements. Keystone First's policies and procedures must be followed for Non-Covered Medicare services.

Policies and Procedures

Medically Necessary

A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- 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

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis, must be documented in writing.

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

Alerts

Benefit Limits and Co-Payments

There may be benefit limits or co-payments associated with the services mentioned in this section. Please refer to the Benefits Grid located in Appendix I of this Manual or in the Provider Center at www.keystonefirstpa.com.

Authorization and Eligibility

Due to possible interruptions of a Member's State Medical Assistance coverage, it is strongly recommended that Providers call for verification of a Member's continued eligibility on the 1st of each month when a Prior Authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the Provider must call Keystone First's Utilization Management Department to obtain Prior Authorization for continuation of service.

DHS Medical Assistance Program Services

The DHS Medical Assistance Program Services ensures requests for Medically Necessary care and services to Keystone First and the appropriate BH-MCO are responded to in a timely manner. This service helps all Medical Assistance consumers who are enrolled in the HealthChoices Program.

Calls are answered by nurses who work for DHS. If a Health Care Provider or Member requests medical care or services, and Keystone First or the BH-MCO has not responded in time to meet the Health Care Provider or Member's needs, call the Service. A Health Care Provider or

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Member can call if Keystone First or the BH-MCO has denied Medically Necessary care or services or will not accept a request to file a Grievance, or if they are having trouble getting shift home health services that have been authorized by Keystone First.

The Service operates Monday through Friday between 9:00 a.m. and 5:00 p.m.. To reach the Service call **1-800-537-8862**. The Service cannot provide or approve urgent or emergency medical care.

Ambulance

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

Keystone First will assist Members in accessing non-ambulance transportation services for physical health appointments through the Medical Assistance Transportation Program (MATP); however Keystone First is not financially responsible for payment for these services. Members should be advised to contact the BH-MCO in their county of residence for assistance in accessing non-ambulance transportation for behavioral health appointments.

County	MATP Service Phone Number
Bucks	215-794-5554 or 888-795-0740
Chester	610-594-3911 or 877-873-8415
Delaware	610-490-3960 or 866-450-3766
Montgomery	215-542-7433
Philadelphia	267-515-6400 or 877-835-7412
MATP web site	http://matp.pa.gov/

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

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

- The Member is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the Member
- There is reason to suspect serious internal or head injury
- The Member requires physical restraints
- The Member requires oxygen or other life support treatment en route
- Because of the medical history of the Member and present condition, there is reason to believe that oxygen or life support treatment is required en route
- The Member is being transported to the nearest appropriate medical facility

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- The Member is being transported to or from an appropriate medical facility in connection with services that are covered under the MA Program
- The Member requires transportation from a hospital to a non-hospital drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not Medically Necessary in an inpatient facility

Behavioral Health Services

Behavioral Health Services, including all mental health, drug and alcohol services are coordinated through and provided by:

Bucks County	Magellan Behavioral Health	1-877-769-9784
Chester County	Community Care Behavioral Health	1-866-622-4228
Delaware County	Magellan Behavioral Health	1-888-207-2911
Montgomery County	Magellan Behavioral Health	1-877-769-9782
Philadelphia County	Community Behavioral Health	1-888-545-2600

Members may self-refer for behavioral health services. However, PCPs and other physical healthcare providers often need to recommend that a Member access behavioral health services. The Health Care Provider or his/her staff can obtain assistance for Members needing behavioral health services by calling the toll free numbers noted above.

Cooperation between Network Providers and the BH-MCOs is essential to assure Members receive appropriate and effective care. Network Providers are required to:

- Adhere to state and Federal confidentiality guidelines for Member medical records, including obtaining any required written Member consents to disclose confidential mental health and drug and alcohol records.
- Refer Members to the appropriate BH-MCO, once a mental health or drug and alcohol problem is suspected or diagnosed
- To the extent permitted by law, participate in the appropriate sharing of necessary clinical information with the Behavioral Health Provider including, if requested, all prescriptions the Member is taking.
- Be available to the Behavioral Health Provider on a timely basis for consultation
- Participate in the coordination of care when appropriate
- Make referrals for social, vocational, educational and human services when a need is identified through an assessment
- Refer to the Behavioral Health Provider when it is necessary to prescribe a behavioral health drug, so that the Member may receive appropriate support and services necessary to effectively treat the problem

The BH-MCO provides access to diagnostic, assessment, referral and treatment services including but not limited to:

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)
- EPSDT behavioral health rehabilitation services for Members up to age 21

Health Care Providers may call Keystone First's Member Services Department at **1-800-521-6860** whenever they need help referring a Member for behavioral health services.

Dental Services

Members do not need a referral from their PCP, and can choose to receive dental care from any provider who is part of the dental network. Member inquiries regarding covered dental services should be directed to Keystone First's Member Services Department at **1-800-521-6860**.

Providers with inquiries regarding covered dental services should call Keystone First Dental Provider Services at 877-408-0878. Provider Services staff are available Monday-Friday 8:00A.M. – 6:00 P.M.

All Members have dental benefits. Contact Keystone First Dental Provider Services at 1-877-408-0878 for more information.

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

A co-payment may apply per visit to a dental provider for members 18 years of age and older. See page 23 for the complete list of co-payments.

Dental Benefits for Children under the age of 21

Children under the age of 21 are eligible to receive all Medically Necessary dental services. Children may go to any dentist that is part of Keystone First's network. Participating dentists can be found in our online provider directory at www.keystonefirstpa.com or by calling Member Services at 1-800-521-6860.

Dental services that are covered for children under the age of 21 include the following, when Medically Necessary:

- Anesthesia
- Orthodontics*
- Check-ups
- Periodontal services
- Cleanings
- Fluoride Treatments (topical fluoride varnish can also be done by a PCP or CRNP)**
- Root Canals
- Crowns
- Sealants
- Dentures
- Dental surgical procedures
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

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**If braces were put on before the age of 21, Keystone First will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains eligible for Medical Assistance and is still a Member of Keystone First. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the member loses eligibility, Keystone First will pay for services through the month that the member is eligible. If a member loses eligibility during the course of treatment, you may charge the member for the remaining term of the treatment after Keystone First's payments cease ONLY IF you obtained a written, signed agreement from the member prior to the onset of treatment. For case specific clarification, please contact the Keystone First Dental Director.*

****Participating PCPs and CRNPs with appropriate training and certification may administer and bill for fluoride varnish treatments for children less than five (5) years old up to a maximum of four (4) times per year. Fluoride varnish is defined as a service provided by a participating PCP or CRNP where each tooth of a child less than 5 years old is painted with a fluoride solution under a specific application protocol.**

Providers are expected to take the on-line "*Caries Risk Assessment, Fluoride Varnish & Counseling*" educational course before administering fluoride varnish. The link to the training module is available in the Provider Center at www.keystonefirstpa.com

Dental Benefits for Members age 21 and older

The following dental services are covered for Members with dental benefits who are age 21 and older:

- Check-ups**
- Cleanings**
- X-rays
- Fillings
- Crowns and adjunctive services* and **
- Extractions
- Root Canals* and **
- Dentures * and**
- Surgical procedures*
- Anesthesia*
- Emergencies
- Periodontal* and **
- Endodontics**

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

** Benefit Limit Exceptions apply

Keystone First dental benefits for Members age 21 and older include:

- 1 dental exam and 1 cleaning per provider every 180 days

- Re-cementing of crowns
- Pulpotomies to provide symptomatic relief of dental pain
- Dentures: one removable prosthesis per member, per arch, regardless of type (full/partial), per lifetime
 - If the member received a partial or full upper denture since April 27, 2015, paid for by Keystone First, other MCO's, or the state's fee-for-service plan, he/she may be able to get another partial or full upper denture. Additional dentures will require a benefit limit exception.

Benefit Limit Exception Process

Members age 21 and over may be eligible to receive crowns and adjunctive services, root canals, additional dentures, additional cleanings and exams, other endodontic services and periodontal services through the benefit limit exception process. Keystone First participating dentists should call Keystone First Dental Provider Services at 1-877-408-0878 to request a benefit limit exception. Refer to the Dental Provider Supplement Manual for detailed information about the Benefit Limit Exception Process.

Keystone First will grant benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member; or
- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the Member; or
- Granting a specific exception is a cost effective alternative for Keystone First; or
- Granting an exception is necessary in order to comply with federal law; or
- The Member is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for periodontal services included in Keystone First's benefit program.

For any questions on eligibility or dental benefits, please contact the Provider Services Department at **1-800-521-6007**

Durable Medical Equipment

Covered Services

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

All DME purchases or monthly rentals that cost more than \$750, and all wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or Member age must be Prior Authorized. In addition, certain conditions apply to the following supplies:

Enteral Nutritional Supplements:

- Prior Authorization is required for Members age 21 and over regardless of cost.
- Prior Authorization is required when the request is in excess of \$350/month for Members under the age of 21. If the Enteral Nutritional Supplements requested is the only source of nutrition for the Member, the request shall be approved.

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- All requests for Enteral Nutritional Supplements for Members under the age of 5 must be checked for WIC eligibility by the provider prior to the request
- Requests with a diagnosis of AIDS are processed following the guidelines regarding waiver information found on the DHS website at:
<http://www.dhs.pa.gov/learnaboutdhs/waiverinformation/>

Diapers/pull-up diapers:

Keystone First has partnered with the following vendors to supply incontinence supplies. These vendors will deliver supplies directly to a member's home through a drop ship program. Prior authorization is not required when ordering through:

- J&B Medical Supply (1-866-240-9792)
- Bright Medical Supply (1-800-345-4268)
- King of Prussia Pharmacy (1-800-935-9153)
- Matts Pharmacy & Medical Supply (215-785-3537)

Providers may contact these vendors at the numbers listed above to make the necessary delivery arrangements.

Prior authorization is required for diaper/pull-up diapers if:

- Members 3 years of age and over are requesting to have:
 - More than 300 generic diapers and/or pull-up diapers per month.
 - Brand-specific diapers.
 - Diapers supplied by a provider other than those listed above.

PCPs, Specialists and Hospital Discharge Planners are directed to contact Keystone First's Utilization Management Department at **1-800-521-6622**. Because Members may lose eligibility or switch plans, DME Providers are directed to contact Member Services for verification of the Member's continued Medical Assistance eligibility and continued enrollment with Keystone First when equipment is authorized for more than a one month period of time. Failure to do so could result in Claim denials.

Occasionally, Members require equipment or supplies that are not traditionally included in the MA Program. Keystone First will reimburse participating DME Network Providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies not covered by the MA Program but covered under Title XIX of the Social Security Act, provided that the equipment or service is Medically Necessary and the Network Provider has received Prior Authorization from Keystone First. In order to receive Prior Authorization, the requesting Network Provider can fax a letter of medical necessity to Keystone First at **215-937-5383**.

The letter of medical necessity must contain the following information:

- Member's name
- Member's ID number
- The item being requested
- Expected duration of use

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- A specific diagnosis and medical reason that necessitates use of the requested item.

Each request is reviewed by a Keystone First Physician Advisor. Occasionally, additional information is required and the Network Provider will be notified by Keystone First of the need for such information. If you have questions regarding any DME item or supply, please contact the DME Unit at **1-800-521-6622** or the Provider Services Department at **1-800-521-6007**.

Elective Admissions and Elective Short Procedures

In order for Keystone First to monitor quality of care and utilization of services, all Providers are required to obtain Prior Authorization from the Utilization Management Department **1-800-521-6622** for all non-emergency elective medical/surgical inpatient hospital admissions, as well as certain specific procedures performed in a SPU. See "Prior Authorization Requirements" earlier in this Section.

- In order to qualify for payment, Prior Authorization is mandatory for designated procedures done in a SPU and elective inpatient cases
- Keystone First will accept the hospital or the attending Network Provider's request for Prior Authorization of elective inpatient hospital and/or designated SPU admissions, however, neither party should assume the other has obtained Prior Authorization
- To prior authorize an elective inpatient or designated SPU procedure, practitioners are requested to contact the Utilization Management Department at **1-800-521-6622**
- The Prior Authorization request will be approved when medical necessity is determined
- Procedures scheduled for the following calendar month can be reviewed for medical necessity; however, Keystone First cannot verify the Member's eligibility for the date of service. The Network Provider is required to verify eligibility prior to delivering care. Contact the Provider Services Department at **1-800-521-6007** or check eligibility online at www.navinet.net.
- SPU procedures, which have been prior authorized for a particular date, may require rescheduling. The SPU authorizations are automatically assigned a fourteen (14) day window (the scheduled procedure date plus thirteen 13 days during which a SPU procedure can be rescheduled without notifying Keystone First). Should the rescheduled date cross a calendar month, the Network Provider is responsible for verifying that the Member is still eligible with Keystone First before delivering care

Denied Prior Authorization requests may be appealed to the Medical Director or his/her designee. See "Provider Dispute/Appeal Procedures; Member Complaints, Grievances and Fair Hearings" in Section VII of this Manual for information on how to file an appeal.

Note:

Behavioral health admissions must be coordinated with the appropriate BH-MCO:

Bucks County	Magellan Behavioral Health	1-877-769-9784
Chester County	Community Care Behavioral Health	1-866-622-4228
Delaware County	Magellan Behavioral Health	1-888-207-2911
Montgomery County	Magellan Behavioral Health	1-877-769-9782
Philadelphia County	Community Behavioral Health	1-888-545-2600

Emergency Admissions, Surgical Procedures and Observation Stays

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

- ER Medical Care
- Emergency Surgical Procedure Unit (SPU) Service
- Emergent Observations Stay Services - Maternity & Other Medical/Surgical Conditions
- Emergency Inpatient Admission
- Emergency Medical Services

ER Medical Care

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

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

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

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

Additional resources addressing mandatory reporter requirements:

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

Emergency Medical Services

Emergency Room Policy

"An Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions (or)
- Serious dysfunction of any bodily organ or part

Prior Authorization/Notification for ER Services/Payment:

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

PCP Contact Prior to ER Visit

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

Authorization of Inpatient Admission Following ER Medical Care

If a Member is admitted as an inpatient following ER Medical Care, a separate phone call is required to the Utilization Management Department at **1-800-521-6622** for authorization or electronically through JIVA on the provider web portal of NaviNet within 24 hours of admission. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period within 48 hours of admission. The information should include treatment received in the ER; the response to treatment; result of post-treatment diagnostic tests; and the treatment plan. All ER charges are to be included on the inpatient billing form. Reimbursement for authorized admissions will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER Services. The inpatient case reference number should be noted on the bill.

Emergency SPU Services

When trauma, injury or the progression of a disease is such that a Member requires:

- Immediate surgery, and
- Monitoring post-surgery usually lasting less than twenty-four (24) hours, with

- Rapid discharge home, and
- Which cannot be performed in the ER

The ER staff should provide Medically Necessary services to stabilize the Member and then initiate transfer to the SPU.

Authorization of Emergency SPU Services

Prior Authorization of an Emergency SPU service is not required. However, the hospital is responsible for notifying Keystone First's Utilization Management Department within forty-eight (48) hours or by the next business day following the date of service (whichever is later) for all Emergency SPU Services. Notification can be given either by phone or fax, utilizing the Hospital Notification of Emergency Admissions Form (See the Appendix of the Manual for the form).

Authorization of Inpatient Admission Following Emergency SPU Services

If a Member is admitted as an inpatient following Emergency SPU Services, notification is required within 24 hours to the Utilization Management Department at **1-800-521-6622** for authorization, or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The facility clinical staff should be prepared to provide additional information to support the need for continued medical care beyond 24 hours such as: procedure performed, any complications of surgery, and immediate post-operative period vital signs, pain control, wound care etc. All ER and SPU charges are to be included on the inpatient billing form. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or SPU services. The inpatient case reference number should be noted on the bill.

Emergent Observation Stay Services

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

Observation Care can be broken down into two categories:

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

Maternity/Obstetrical Observation Stay

A Maternity Observation Stay is defined as a stay usually requiring less than forty-eight (48) hours of care for the monitoring and treatment of patients with medical conditions related to pregnancy, including but not limited to:

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

- Hyperemesis
- Gestational Diabetes

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

ER Medical Care rendered to a pregnant Member that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation. See "Claims Filing Instructions" in the appendix of the Manual for Claim submission procedures.

Authorization of Inpatient Admission Following OB Observation

If a Member is admitted after being observed, notification is required within 24 hours to the Utilization Management Department at **1-800-521-6622** for authorization, or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. If the hospital does not have an L&D Unit, the hospital ER staff will include in their medical screening a determination of the appropriateness of treating the Member at the hospital versus the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For Members who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest Keystone First participating hospital. Hospitals where Members are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a weekend, the hospital staff should facilitate the transfer and notify Keystone First's Patient Care Management Department via a phone call or fax the first business day following the transfer.

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

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

Medical Observation Stay

A Medical Observation Stay is defined as a stay requiring less than forty-eight (48) hours of care for the observation of patients with medical conditions including but not limited to:

- Head Trauma
- Chest Pain

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

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

Authorization of Inpatient Admission Following Medical Observation

If a Member is admitted as an inpatient following a Medical Observation Stay, notification is required within 24 hours to the Utilization Management Department at **1-800-521-6622** for authorization or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the Member as an inpatient versus retention in the Observation Care setting of the facility. If the Member is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all Claims related to the inpatient stay.

Emergency Inpatient Admissions

Emergency Admissions from the ER, SPU or Observation Area

If a Member is **admitted** after being treated in an Observation, SPU or ER setting of the hospital, the hospital is responsible for notifying Keystone First's Utilization Management Department **within 24 hours** or by the **next business day** (whichever is later) following the date of service (admission). Notification can be given either by phone **1-800-521-6622** or fax **1-888-800-9005** utilizing the **Hospital Notification of Emergency Admissions form** (see the Appendix of the Manual for a copy of the form; the form can also be found in the Provider Forms section on www.keystonefirstpa.com), or electronically through JIVA on the provider web portal of NaviNet. See the Provider Services section of the manual for details on how to access JIVA through NaviNet. The Observation, SPU or ER charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the Observation, SPU or ER services. The inpatient case reference number should be noted on the bill.

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

Utilization Management Inpatient Stay Monitoring

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

As a condition of participation in the Keystone First Network, Providers must agree to the UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days, according to established criteria, under the direction of the Keystone First Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, Keystone First must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care

Emergency Services Provided by Non-Participating Providers

Keystone First will reimburse Health Care Providers who are not enrolled with Keystone First when they provide Emergency Services for a Keystone First Member.* However, to comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), all providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made. This applies to non-participating out-of-state providers as well.

Enroll by visiting: <http://provider.enrollment.dpw.state.pa.us/>

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

Non-Participating Providers can find the complete Non-Participating Emergency Services Payment Guidelines in the Appendix of the on-line Provider Manual in the Provider Center of www.keystonefirstpa.com

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

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

Family Planning

Members are covered for Family Planning Services without a referral or Prior Authorization from Keystone First. Members may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Keystone First Network. Members that have questions or need help locating a Family Planning Services provider can be referred to Member Services at 1-800-521-6860.

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

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

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

Sterilization

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

A Member seeking sterilization must voluntarily give informed consent on the Department of Human Service's **Sterilization Consent Form (MA 31 form)** (see **Appendix for sample form**). The informed consent must meet the following conditions:

- The Member to be sterilized is at least 21 years old and mentally competent. A mentally incompetent individual is a person who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction unless that person has been declared competent for purposes which include the ability to consent to sterilization.
- The Member knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure
- The Member was counseled on alternative temporary birth control methods
- The Member was informed that sterilization is permanent in most cases, but that there is not a 100% guarantee that the procedure will make him/her sterile
- The Member giving informed consent was permitted to have a witness chosen by that Member present when informed consent was given
- The Member was informed that their consent can be withdrawn at any time and there will be no loss of health services or benefits
- The elements of informed consent, as set forth on the consent form, were explained orally to the Member
- The Member was offered language interpreter services, if necessary, or other interpreter services if the Member is blind, deaf or otherwise disabled
- The Member must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

DHS's Sterilization Consent Form must accompany all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by Keystone First.

Submit claims to:
Keystone First
Family Planning

P.O. Box 7115
London, KY 40742

Home Health Care

Keystone First encourages home health care as an alternative to hospitalization when medically appropriate. Home health care services are recommended:

- To allow an earlier discharge from the hospital
- To avoid unnecessary admissions of Members who could effectively be treated at home
- To allow Members to receive care when they are homebound, meaning their condition or illness restricts their ability to leave their residence without assistance or makes leaving their residence medically contraindicated.

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

- Skilled Nursing
- Infusion Services
- Physical Therapy
- Speech Therapy
- Occupational Therapy

Keystone First's **Special Care/Case Management Department** will coordinate Medically Necessary home care needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. Contact Keystone First's **Special Care/Case Management Department** at **1-800-521-6622**. For Home Infusion care, please call **1-888-557-3100**

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

Hospice Care

If a Member requires hospice care, the PCP should contact Keystone First's Utilization Management Department. Keystone First will coordinate the necessary arrangements between the PCP and the hospice provider in order to ensure receipt of Medically Necessary care. **Keystone First's Utilization Management Department Telephone Number is 1-800-521-6622.**

Hospital Transfer Policy

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

Elective inter-facility transfers must be prior authorized by Keystone First's Utilization Management Department at 1-800-521-6622.

These steps must be followed by the Health Care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient

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

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

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

Medical Supplies

Certain medical supplies are available with a valid prescription through Keystone First's medical benefit, and are provided through participating pharmacies and durable medical equipment (DME) suppliers. Such as:

- Vaporizers (one/365 days)
- Humidifiers (one per/365 days)
- Diapers/Pull-Up Diapers (incontinence supplies) may be obtained as follows:
Keystone First has partnered with the following vendors to supply incontinence supplies. These vendors will deliver supplies directly to a member's home through a drop ship program. Prior authorization is not required when ordering through:
 - J&B Medical Supply (1-866-240-9792)
 - Bright Medical Supply (1-800-345-4268)
 - King of Prussia Pharmacy (1-800-935-9153)
 - Matts Pharmacy & Medical Supply (215-785-3537)

Providers may contact these vendors at the numbers listed above to make the necessary delivery arrangements.

- Requests for diapers/pull-up diapers supplied by any other DME network Provider require Prior Authorization
 - Members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary. A written prescription from Network Provider is required.

REFERRAL & AUTHORIZATION REQUIREMENTS

Authorization is required when supplied by any DME network Provider, other than those listed above.

- Diabetic supplies
 - Insulin, disposable insulin syringes and needles
 - Disposable blood and urine testing agents
 - Blood Glucose Meter (Roche® Products), selected Accu-Chek meters (one per calendar year).
 - Lancets, control solution and strips (for the above meters)
 - Glucose tablets, alcohol swabs (150 per 34 days).
- Blood pressure monitors less than \$60 are covered by Keystone First with a prescription. Coverage is currently limited to one (1) unit per 365 days. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Spacers are covered under Keystone First's pharmacy benefit. Quantity limits are two per calendar year. Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- Peak flow meters (one per calendar year). Requests that exceed these limits should be referred to the prior authorization department for medical necessity review.
- For current price and quantity limits, or to request school supply or replacement of a lost device, contact Pharmacy Services at 1-800-588-6767.

Newborn Care

Keystone First assumes financial responsibility for services provided to newborns of mothers who are active Members. However, these newborns are not automatically enrolled in Keystone First at birth.

The hospital should complete and submit an MA-112 form to DHS whenever a Member delivers. (This form can be found in the Appendix or on the Provider Center at www.keystonefirstpa.com. The newborn cannot be enrolled in Keystone First until DHS opens a case and lists him/her as eligible for Medical Assistance. Processing of newborn Claims will be delayed pending DHS's completion of this process. However, in order to protect the Health Care Provider's timely filing rights, facility charges for newborn care can be billed on a separate invoice using the mother's Keystone First ID number but with the newborn's name and date of birth. These Claims will be pending until the newborn number is available. Keystone First will pay newborn charges according to the hospital's contracted rates.

Health Care Provider charges for circumcision and inpatient newborn care must be billed under the newborn's Keystone First ID number.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screens must be completed on every newborn, and submitted to Keystone First's Claims Processing Department. Please refer to the Pediatric Preventative Health Care Program in this section of the manual for EPSDT instructions.

Detained Newborns and Other Newborn Admissions

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

- Keystone First regards a baby **detained** after the mother's discharge as a new admission. The admission must be reported to Keystone First's Utilization Management Department within 24 hours and a new case reference number will be issued for the detained baby.
- Facilities are required to notify Keystone First of all admissions to an **Intensive Care** or **Transitional Nursery** within 24 hours of the admission (even if the admission does not result in the baby being detained).
- Facilities are also required to notify Keystone First of all newborn admissions where the payment under their contract will be at other than the newborn rate associated with DRG 6401 (even if the baby is not detained or admitted to an Intensive Care or Transitional Nursery).

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

Facilities should call the Utilization Management Department at **1-800-521-6622** and follow prompts. When calling in detained baby or other newborn admission notifications, please be prepared to leave the following information:

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

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

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

Nursing Facility

Covered Services

If a Member needs to be referred to a Nursing Facility, the PCP or representative from the transferring hospital should contact Keystone First's Utilization Management Department. Keystone First will coordinate necessary arrangements between the PCP, the referring facility, the Nursing Facility, and the Options Assessment Program in order to provide the needed care.

The Options Assessment Program was implemented by DHS to identify individuals who are reviewed by the Options Assessment Unit and considered eligible for long-term care using two criteria: (1) must be over 18 years of age and (2) meet the criteria for nursing home level of care. Once the Options Assessment is completed Members may qualify for long-term care if they have multiple needs, which may include: severe mental health conditions; severe developmental delays/Intellectual Disability conditions; paraplegia/quadruplegia; elderly. Keystone First is not responsible for providing or paying for the Options Assessment. Network Providers are responsible for contacting the Area Agency on Aging to initiate an Options Assessment for a Member in need of long-term care in a nursing home. The phone numbers for the Area Agencies on Aging are:

Bucks County Office on Aging	215-348-0510
Chester County Department of Aging Services	610-344-6009
Delaware County Office of Services for the Aging	610-490-1300
Montgomery County Office on Aging and Adult Services	610-278-3601
Philadelphia Corporation for Aging	215-765-9000

It should be noted, per Keystone First's agreement with DHS, that Keystone First will be financially responsible for payment for up to 30 days of nursing home care (including hospital reserve or bed hold days) if a Member is admitted to a Nursing Facility. Keystone First Members will be disenrolled on the 31st day following the admission date to the Nursing Facility as long as the Member has not been discharged (from the Nursing Facility). On day thirty-one (31), the Nursing Facility should begin billing the MA Program as the Member will be disenrolled from Keystone First.

To report admission of a Member, Nursing Facilities should call the Keystone First's Utilization Management Department as soon as possible, prior to or after admission. In the event that verification is subsequently needed to document that the Nursing Facility notified Keystone First of the admission of one of its Members, the Nursing Facility should follow up on the initial contact to Keystone First with written correspondence to:

Keystone First
Utilization Management Department
200 Stevens Drive
Philadelphia, PA 19113

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

OB Network Providers are encouraged to refer smoking mothers to the smoking cessation program. Additional information on the Smoking Cessation Program is located in the Special Needs and Case Management Section of the Manual.

Ophthalmology Services

Non-Routine Eye Care Services

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

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

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

Outpatient Laboratory Services

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

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

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

REFERRAL & AUTHORIZATION REQUIREMENTS

PLEASE NOTE: ALL MEMBER ID CARDS IDENTIFY THE ASSIGNED LABORATORY

The image shows two examples of Keystone First BlueCross member ID cards. The left card displays member information for 'Keystone First' including member name, ID, PCP, and copays. The right card displays contact information and instructions for using the card.

Member Information	PCP Information	Copays
Member Name: Last name, First name Keystone First ID: YXV123456789	PCP: (556) 555-1234 Lab: XXXXXXXX Dental: XXXXXXXX	ER: XX PCP: XX SPEC: XX RX(G): XX RX(B): XX

Additional information on the right card includes: Member Services: 1-800-421-6269, TTY: 1-800-421-6269; Pharmacy Provider Services: 1-800-521-6007; In-area providers: 1-800-521-6022; Out-of-area providers: 1-800-476-BLUE; Medical Health, Drug and Alcohol Services: 1-800-521-6000; Pharmacy Provider Services: 1-800-521-6000.

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

Mobile Phlebotomy/Home Draw

Keystone First has made arrangements for mobile phlebotomy services for our home-bound members. When home phlebotomy services are needed, the office should call one of the mobile providers (refer to one of the providers in the Appendix) and arrange for the needed service.

Please refer to the Provider Center at www.keystonefirstspa.com or the Appendix for a listing of laboratories, phlebotomy drawing sites and providers of mobile phlebotomy services.

Outpatient Renal Dialysis

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

Free-Standing Facilities

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

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

Hospital Based Outpatient Dialysis

Keystone First will reimburse Hospital Based Outpatient Dialysis facilities for all of the above services including certain lab tests and diagnostic studies that, according to Medicare guidelines,

are billable above the Medicare composite rate. Please refer to Medicare Billing Guidelines for billable End Stage Renal Disease tests and diagnostic studies.

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

The following services require Prior Authorization through Keystone First’s Utilization Management Department:

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

Outpatient Testing

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

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialist should note the Member’s information and procedures to be performed on his/her office prescription form. Refer to “**Prior Authorization Requirements**” section of the Manual for a complete list of procedures requiring Prior Authorization.

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

Outpatient Therapies

Physical, Occupational, and Speech

Members are entitled to 24 physical, 24 occupational, and 24 speech therapy outpatient visits within a calendar year. A referral from the Member's PCP is required for the initial visit to the therapist. Initial visits are not considered part of the 24 visits.

Once the Member exceeds the 24 visits of physical, occupational, and/or speech therapy, an authorization is required to continue services. The therapist must contact Keystone First’s Utilization Management Department at **1-800-521-6622** to obtain an authorization.

Pediatric Preventive Health Care Program

Known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Liaisons in the EPSDT Department assist the Parents or Guardians of all Members younger than twenty-one (21) years of age in receiving EPSDT screens, treatment, follow-up, and referrals to the Early Intervention Program when appropriate. The EPSDT liaison also facilitates and ensures EPSDT compliance, provides follow-up concerning service issues, educates non-compliant Members on Keystone First's rules and regulations, and assists Members in accessing care.

The quantity of Medically Necessary, Title XIX eligible services for enrolled children younger than twenty-one (21) years of age are not restricted or limited.

EPSDT Screens

Under EPSDT, State Medicaid agencies must provide and/or arrange for the promotion of services to eligible children younger than twenty-one (21) years of age that include comprehensive, periodic preventive health assessments. All Medically Necessary immunizations are required. Age appropriate assessments, known as "screens," must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever a health care provider suspects the child may have a health problem. Treatment for all Medically Necessary services discovered during an EPSDT screening is also covered.

EPSDT Screens must include the following:

- A comprehensive health and developmental history, including both physical and mental health development
- A comprehensive unclothed exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests including blood lead level assessment
- Health education including anticipatory guidance

EPSDT Covered Services

The following services are covered under the EPSDT Program:

- Comprehensive screens according to a predetermined periodicity schedule (found in the Provider Center at www.keystonefirstpa.com):
 - Children ages birth through 30 months should have screening visits at the following intervals: by 1 month, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
 - Children and adolescents ages 3 years to 21 years of age are eligible for annual screens.
- After completion of a screen, Members are entitled to all services included in the approved DHS State Plan for diagnosing and treating a discovered condition. Included in this plan are:
 - Eye Care
 - Hearing Care, including hearing aids
 - Dental Care (referral to dentist for dental screening is required annually for all children aged 3 years and older as part of a complete EPSDT screen)

In addition, Keystone First will pay for routine health assessments, diagnostic procedures, and treatment services provided by Network Providers and clinics, as well as vision and hearing services, and dental care, including orthodontics.

Keystone First complies with the relevant OBRA provisions regarding EPSDT by implementing the following:

- Health education is a required component of each screening service. Health education and counseling to parent (or guardian) and children is designed to assist in understanding what to expect in terms of the child's physical and cognitive development. It is also designed to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention
- Screening services are covered at intervals recommended by the Academy of Pediatrics and the American Dental Association. An initial screening examination may be requested at any time, without regard to whether the member's age coincides with the established periodicity schedule
- Payment will be made for Medically Necessary diagnostic or treatment services needed to correct or ameliorate illnesses or conditions discovered by the screening services, whether or not such diagnostic or treatment services are covered under the State Medicaid Plan and *provided that it* is covered under Title XIX of the Social Security Act. However, Network Providers should be aware that any such service must be prior-authorized and that a letter of medical necessity is required

EPSDT Expanded Services

EPSDT Expanded Services are defined as any Medically Necessary health care services provided to a Medical Assistance recipient younger than twenty-one (21) years of age that are covered by the federal Medicaid Program (Title XIX of the Social Security Act), but not currently recognized in the State's Medicaid Program. These services, which are required to treat conditions detected during an encounter with a health care professional, are eligible for payment under the Federal Medicaid Program, but are not currently included under DHS's approved State Plan. EPSDT Expanded Services may include items such as medical supplies or Enteral formula, for example. Additional information on EPSDT Screening Requirements is located in the later portion of this section.

Eligibility for EPSDT Expanded Services

All Members younger than twenty-one (21) years of age are also eligible for EPSDT Expanded Services, when such services are determined to be Medically Necessary. There is no limitation on the length of approval for services, as long as the conditions for medical necessity continue to be met and the Member remains eligible for Keystone First benefits.

EPSDT Expanded Services Requiring Prior Authorization

EPSDT Expanded Services require Prior Authorization. All requests for EPSDT Expanded Services should be forwarded to Keystone First's Utilization Management Department where they will be reviewed for medical necessity. Requests should be accompanied by a letter of medical necessity outlining the rationale for the request and the benefit that the requested service(s) will yield for the Member. Although Utilization Management will accept letters of medical necessity from a Member's PCP, a participating Specialist or Ancillary Health Care Provider, the PCP will be asked to approve the treatment plan.

Obtaining PCP Approval for EPSDT Expanded Services

When a request for EPSDT Expanded Services and letter of medical necessity are received without prior approval from the PCP, Utilization Management will contact the PCP to obtain his/her approval. If Utilization Management is unsuccessful after one week of repeated attempts to reach the PCP, the author of the letter of medical necessity will be verbally informed of Keystone First's inability to reach the PCP. The author will be asked to intervene by reaching the PCP to discuss the request. When the PCP is contacted but does not approve the request, he/she will be asked to contact the requesting Network Provider to discuss the case and offer alternatives.

EPSDT Expanded Services Approval Process

When the Keystone First Medical Director or his/her designee approves a request for EPSDT Expanded Services, the requesting Network Provider will be asked to identify a Network Provider for the service if this was not already done. The provider of service should contact Keystone First's Utilization Management Department at 800-521-6622 for a case reference number. The provider of service will be responsible for conducting Concurrent Reviews with Keystone First's Utilization Management Department to obtain authorization to extend the approval of services. The provider of service is also responsible for verifying the Member's eligibility prior to each date of service.

EPSDT Expanded Services Denial Process

Prior to denying any request, the Keystone First Medical Director or his/her designee will make several attempts, as an effort of good faith, to contact the requesting Network Provider to discuss the case. If the request is denied in full or in part, a letter detailing the rationale for the decision will be sent to the Member, the requesting Network Provider, and if identified, the provider of service or advocate working on the behalf of the Member. This letter will also contain information regarding how the decision can be appealed and for Members, information on how to contact community legal service agencies who might be able to assist in filing the Grievance.

Keystone First will honor EPSDT Expanded Service treatment plans that were approved by another HealthChoices Managed Care Organization or DHS, prior to the Member's Enrollment with Keystone First. The Health Care Provider of service is responsible for forwarding documentation of the prior approval in order for Keystone First to continue to authorize previously approved services. Keystone First will not interrupt services pending a determination of medical necessity in situations where the Health Care Provider is unable to document the approval of services by the previous insurer.

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS 1500 or UB-04 paper claim forms or electronically, using the 837 format.

Providers choosing to bill for complete EPSDT screens, including immunizations, on the CMS 1500 or UB-04 claim form or the 837 electronic formats must:

- Use **Z76.1, Z76.2, Z00.121 or Z00.129 as the primary diagnosis code**
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 - Outpatient Lab; U1 - Autism.
 - ✓ Use U1 modifier in conjunction with CPT code 96110 for Autism screening
 - ✓ CPT code 96110 without a U1 modifier is to be used for a Developmental screening

Age Appropriate Evaluation and Management Codes

(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:

99460 Newborn Care (during the admission) 99463 Newborn (same day discharge)

New Patient:

99381 Age < 1 yr
99382 Age 1-4 yrs
99383 Age 5-11 yrs
99384 Age 12-17 yrs
99385 Age 18-20 yrs

Established Patient:

99391 Age < 1 yr
99392 Age 1-4 yrs
99393 Age 5-11 yrs
99394 Age 12-17 yrs
99395 Age 18-20 yrs

Billing example: New Patient EPSDT screening for a 1 month old. The diagnosis and procedure code for this service would be:

- Z76.2 (Primary Diagnosis)
- 99381EP (E&M Code with “Complete” modifier)

* Enter a zero (\$0.00) or actual charged amount (including capitated services). A blank is not valid and will be rejected.

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. (Both are available in a printable PDF format online at the Provider Center at www.keystonefirstpa.com)

Completing the CMS 1500 or UB-04 Claim Form

The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:

- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier

REFERRAL & AUTHORIZATION REQUIREMENTS

➤ EPSDT/Family Planning

UB-04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use EPSDT Referrals	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental *(Required for ages 3 and over) YO* – Other YV – Vision YH – Hearing YB – Behavioral YM – Medical <i>* Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through the CONNECT Helpline at 1-800-692-7288, document the referral in the child’s medical record and submit the YO EPSDT referral code.</i>	C C C C C C
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, diagnosis code Z76.1, Z76.2, Z00.121 or Z00.129 (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. An appropriate diagnosis code must be included for each referral. Immunization Codes are not required.	R
42	N/A	Revenue code	Enter Revenue Code 510	R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a “complete” EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	Enter Visit Code 03 when providing EPSDT screening services.	R

Key:

- **Block Code** – Provides the block number as it appears on the claim.
- **C** – Conditional must be completed if the information applies to the situation or the service provided.
- **R** – Required – must be completed for all EPSDT claims.

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Additional EPSDT Information

Screening Eligibility and Required Services

For screening eligibility information and services required for a complete EPSDT screen, please consult the:

- EPSDT Program Periodicity Schedule and Coding Matrix
- Recommended Childhood Immunization Schedule

(Both schedules are available in the Appendix of the Manual and in a printable PDF format in the Provider Center at www.keystonefirstpa.com)

You may direct EPSDT program specific questions to Keystone First’s EPSDT Outreach Department at 1-888-765-9569.

Family and Medical History for EPSDT Screens

It is the responsibility of each Network Provider to obtain a Family and Medical History as part of the initial well-child examination.

The following are the Family and Medical History categories, which should be covered by the Network Provider:

- Family History
 - Hereditary Disorders, including Sickle Cell Anemia
 - Hay fever - Eczema - Asthma
 - Congenital Malformation
 - Malignancy - Leukemia
 - Convulsions - Epilepsy
 - Tuberculosis
 - Neuromuscular disease
 - Intellectual Disability Mental Illness in parent requiring hospitalization
 - Heart disease
 - Details of the pregnancy, birth and neonatal period
 - Complication of pregnancy
 - Complication of labor and delivery
 - Birth weight inappropriate for gestational age
 - Neonatal illness

- Medical History
 - Allergies, Asthma, Eczema, Hay Fever
 - Diabetes
 - Epilepsy or convulsions
 - Exposure to tuberculosis
 - Heart Disease or Rheumatic Fever
 - Kidney or Bladder problems
 - Neurological disorders
 - Behavioral disorders
 - Orthopedic problems
 - Poisoning
 - Accidents
 - Hospitalizations/Operations
 - Menstrual history
 - Medication

Height

Height must be measured on every child at every well-child visit. Infants and small children should be measured in the recumbent position, and older children standing erect. The height should be recorded in the child's medical record and should be compared to a table of norms for age. The child's height percentile should be entered in the child's medical record. Further study or referral is indicated in a child who has deviated from his/her usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th or below the 3rd percentile).

Weight

Weight must be measured on every child at every well-child visit. Infants should be weighed with no clothes on, small children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight should be recorded in the child's medical record, and should be compared to a table of norms for age. The child's weight percentile should also be entered in the child's medical record. Further study or referral is indicated for a child who has deviated from his usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th percentile or below the 3rd percentile).

Head Circumference

Head circumference should be measured at every well-child visit on infants and children up to the age of two years. Measurement may be done with cloth, steel or disposable paper tapes. The tape is applied around the head from the supraorbital ridges anteriorly, to the point of posteriorly giving the maximum circumference (usually the external occipital protuberance). Further study or referral is indicated for the same situations described in height and weight, and findings should be recorded in the child's medical record.

Blood Pressure

Blood pressure must be done at every visit for all children older than the age of three (3) years, and must be done with an appropriate-sized pediatric cuff. It may also be done under the age of three years when deemed appropriate by the attending Network Provider. Findings should be recorded in the child's medical record.

Dental Screening

Per the American Academy of Pediatric Dentistry, the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease. *All children ages 3 and above must be referred for an annual dental exam as part of each EPSDT Screening.* Providers should check for the following and initiate treatment or refer as necessary:

- Cavities
- Missing Permanent Teeth
- Fillings present
- Oral infection
- Other Oral Concerns

In completing a dental referral for all children age 3 and above:

- Providers should advise the child's parent or guardian that a dental exam is required according to the periodicity schedule.
- The provider should complete and fax the EPSDT Dental Referral Notification form (available under Forms on the Provider Center of www.keystonefirstpa.com or contact Keystone First Member Services at 1-800-521-6860 while the member is in the office, or within four (4) business days of the visit to notify them that the child is due for a dental exam as part of a complete EPSDT screen.
- Either method of notification fulfills the requirement for the provider to refer the member to a dental home*. Keystone First Member Services will then coordinate with the member and their family to locate a participating dentist and arrange an appointment for the child.
- Documentation of the dental referral should be recorded in the child's medical record and on the claim form by utilizing the appropriate EPSDT dental referral code.

Dental Referral:

- Use the EPSDT modifier EP (Complete Screen) when the process outlined above has been followed.
- Enter the EPSDT referral code YD (dental referral) in field 10d on the CMS 1500 claim form, or field 37 on the UB-04 form.
- When the dental referral has not occurred, submit the claim with the EPSDT modifier 52 (Incomplete Screen).
- ***Payment for a complete screen is determined by the presence of both the EP modifier and YD referral code.**

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Vision Testing

Vision testing must be administered at 3, 4, 5, 6, 8, 10, 12, 15 and 18 years of age.

Technique Tips for Vision Testing

The chart should be affixed to a light-colored wall, with adequate lighting (10-30 foot candles) and no shadows. Ordinary room lighting usually does not provide this much light and the chart will need a light of its own. The 20-foot line on the chart should be set at approximately the level of the eyes of a six (6) year old. Placement of the child must be exactly at 20-feet. Sites that do not have a 20-foot distance at which to test should obtain a 10-foot Snellen chart rather than convert to the 20-foot chart. The eye not being tested must be covered with an opaque occluder; several commercial varieties are available at minimal cost, or the Network Provider may improvise one. The hand may not be used, as it leads to inaccuracies. In older children who seem to have difficulty or in young children, bring the child up to the chart (preferably before testing), explain the procedure and be sure the child understands.

For screening, the tester should start with the big E (20-foot line) and then proceed down rapidly line-by-line, as long as the child reads one letter per line, until the child cannot read. At this critical level, the child is tested on every letter on that line or adjacent line. Passing is reading a majority of letters in a line. It is not necessary to test for every letter on the chart. Tests for hyperopia may be done but are not required.

Referral Standards

Children seven (7) years of age and older should be referred if vision in either eye is 20/30 or worse. Those six (6) and younger should be referred if vision in either eye is 20/40 or worse. A child may be referred if parental complaints warrant or if the doctor discovers a medical reason. (Generally, sitting close to television, without other complaints and with normal acuity, is not a reason for referral.) Children failing a test for hyperopia may be referred.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further need be done. If they fail, refer for re-evaluation to a Keystone First participating Specialist, preferably to the vision provider who prescribed the lenses, regardless of when they were prescribed.

If the Network Provider is unable to render an eye examination, in a child nine (9) years of age or older, because of the child's inability to read the chart or follow directions (e.g., a child with Intellectual Disability), please refer this child to a participating Ophthalmologist.

Hearing Screening

Hearing Screening must be administered to every child 3 years of age and older.

Technique Tips for Hearing Testing

Tuning forks and uncalibrated noisemakers are not acceptable for hearing testing. For children younger than five (5) years of age, observation should be made of the child's reactions to noises and to voices, unless the child is sufficiently cooperative to actually do the audiometry. For audiometry, explain the procedure to the child. For small children, present it as a game. Present one tone loud enough for the child to hear, and explain that when it is heard, the child should

raise his/her hand and keep it raised until the sound disappears. Once the child understands, proceed to the test. Doing one ear at a time, set the decibel level at 25, and testing at 500 HZ.

Then go successively to 1000, 2000, 4000 and 6000. Repeat for the other ear. The quietest room at the site should be used for testing hearing.

Referral Standards

Any cooperative child failing sweep audiometry at any two frequencies should be referred to an otorhinolaryngologist or audiologist. If a child fails one tone, retest that tone with threshold audiometry to be certain it is not a severe single loss. To be certain of the need for referral, the Network Provider should immediately retest all failed tones by threshold audiometry, or, if there is question about the child's cooperation or ability at the time of testing, bring the child back for another sweep audiometry before referring. Please remember that audiometers should be periodically (at least yearly) calibrated for accuracy.

Development/Behavior Appraisal

Since children with slow development and abnormal behavior may be able to be successfully treated if treatment is begun early, it is important to identify these problems as early as possible. Questions must be included in the history that relate to behavior and social activity as well as development. Close observation is also needed during the entire visit for clues to deviations in those areas. The completion of a structured developmental screen is required for ages 9 – 11 months, 18 months and 30 months. Use procedure code 96110 to report the completion of this screen.

Younger than five (5) years of age

In addition to history and observation, some sort of developmental evaluation should be done. In children who are regular patients of the Network Provider site, this may consist of on-going recording, in the child's chart, of development milestones sufficient to make a judgment on developmental progress. In the absence of this, the site may elect to do a Denver Developmental Test as its evaluation.

- Marked slowness in any area should be cause for a referral to a participating Specialist, e.g., developmental center, a MH/MR agency, a development Specialist, a pediatric neurologist or a psychologist. If only moderate deficiencies in one or more areas are found, the child should be re-tested in 30-60 days by the Network Provider
- Social Activity/Behavior - Questions should be asked to determine how the child relates to his family and peers and whether any noticeable deviation in any of his/her behavior exists. The Network Provider should observe for similar behavior in the office
- Speech Development - Attention should be paid to the child's speech pattern to see whether it is appropriate for age. The DASE test may be used as an evaluation.

Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through CONNECT Helpline at 1-800-692-7288 and document the referral in the child's medical record.

For information on the Early Intervention System, please refer to the Special Needs and Case Management section of this Manual.

Five (5) years of age and older

Since the usual developmental tests are not valid at this age, observation and history must be used to determine the child's normality in the areas listed below. Each child should be checked and recorded appropriately. Major difficulty in any one area, or minor difficulty in two or more areas, should be cause for referral to a participating mental health professional for further diagnosis.

- Social Activity/Behavior - Does the child relate with family and peers appropriately?
- School - Is the child's grade level appropriate for his/her age? Has the child been held back in school?
- Peer Relationships
- Physical/Athletic Dexterity
- Sexual Maturation -Tanner Score. A full explanation of Tanner observations and scoring is included the Appendix of the Manual.
- Speech - DASE Test if there is a problem in this area record accordingly, refer appropriately

Autism Screening

A structured autism screen is required at ages 18 months and 24 months. Use procedure code 96110, and modifier U1 to report the completion of this screen.

See the Appendix for a complete and updated guide of requirements and resources for structured screening for developmental delays and autism spectrum disorder.

Children on SSI under the age of 21

With respect to SSI and SSI-related Members under the age of 21, at the first appointment following enrollment, the PCP must make an initial assessment of the health needs of the child over an appropriate period (not to exceed one year), including the child's need for primary and specialty care. The results of that assessment shall be discussed with the family or custodial agency (and, if appropriate, the child) and shall be listed in the child's medical records. The family shall be informed in writing of the plan, and the right to use complaint procedures if they disagree. As part of the initial assessment, the PCP shall make a recommendation regarding whether Case Management Services should be provided to the child, based on medical necessity, and with the families or custodial agency's consent, this recommendation shall be binding Keystone First.

Anemia Screening

Initial measurement of hemoglobin or hematocrit is recommended between 9 and 11 months of age, and required by the 12-month screen. After this, a hematocrit should only be performed if indicated by risk assessment and/or symptoms. All premature or low-birth weight infants should have hemoglobin or hematocrit done on their first well-visit and then repeated according to the schedule above. The results of the test should be entered in the child's medical record.

Diagnosis of anemia should be based on the doctor's evaluation of the child and the blood test. It is strongly suggested that a child with 10 grams of hemoglobin or less (or a hematocrit of 30% or less) be further evaluated for anemia. However, even though 10 grams may represent the lower limit of norm for most of childhood, it should be realized that in early infancy and adolescence these levels should be higher. For those Network Providers who use charts to evaluate hemoglobin/hematocrit normals, it should be emphasized that average or mean Hb/Ht for age is not the level to determine anemia, but rather two standard deviations below the mean.

Sickle Cell

Infants younger than 8 months of age with African-American, Puerto Rican, or Mediterranean parentage should have a sickle test on their first well-child visit, to determine the possibility of sickle cell disease being present. After that age, all children of African-American, Puerto Rican, or Mediterranean parentage should have a sickle test only if they exhibit symptoms of anemia or have an Hb/Ht below the normal levels outlined above, unless they have already been tested and the results are known.

Tuberculin (TB) Test

The American Academy of Pediatrics recommends that a child at high risk for TB exposure should be tested for tuberculosis annually, using the Mantoux test. High risk is identified as:

- Contacts with adults with infectious tuberculosis
- Those who are from, or have parents from, regions of the world with high prevalence of tuberculosis
- Those with abnormalities on chest roentgenogram suggestive of tuberculosis
- Those with clinical evidence of tuberculosis
- HIV seropositive persons
- Those with immunosuppressive conditions
- Those with other medical risk factors: Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure, malnutrition
- Incarcerated adolescents
- Children frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, migrant farm workers

Children with no risk factors who live where TB is not common do not need TB tests. Children at high risk (see list above) should be tested every year.

Children who live in places where TB is common or whose risk is uncertain may be tested at 1, 4, 6 and 11-16 years of ages. For example, Philadelphia has twice as much TB as the national average, so children in Philadelphia should receive Mantoux tests at 1, 4, 6 and 11-16 years of age at least.

It is the responsibility of the PCP's office to secure the results of the TB Test forty-eight to ninety-six (48-96) hours after it has been administered. TB Testing should begin at twelve (12) months, or first well-child visit thereafter, and then at two (2) year intervals, (or yearly, if high risk). Results should be entered in the child's medical record.

Albumin and Sugar

Tests for urinary albumin and sugar should be done on every child routinely at every well-visit. Dip sticks are acceptable. Positive tests should be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

Cholesterol Screening

Cholesterol (Dyslipidemia) screening is a required component at 9, 11 and 18 years of age; if not completed at the 18 year screening it must be done at either the 19 or 20 year screening.

Lead Level Screening

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

- ✓ **ALL** Medicaid eligible children are considered at risk for lead toxicity and **MUST** receive blood lead level screening tests for lead poisoning
- ✓ PCP's are **REQUIRED (regardless of responses to the lead screening questions)** to insure that children be screened for lead toxicity from **nine months to eighteen months and again from two to six years of age**
- ✓ Risk questions should be asked at every visit thereafter
- ✓ Refer to the PA EPSDT Periodicity Schedule in the Appendix for reference or visit the Provider Center at www.keystonefirstpa.com →Resources→EPSDT for an electronic copy

Keystone First recommends, although not indicated on the periodicity schedule, that lead screens be done at nine (9) months of age and again before the second birthday and risk questions asked at every visit thereafter.

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

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

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

<u>Billable Service</u>	<u>CPT Code</u>	<u>Fee</u>
Lead Screening	83655	\$10.00

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

Our representatives are available to you for any questions regarding this problem, its screening details, its diagnosis or its follow-up by calling the EPSDT Outreach Program at 1-888-765-9569

Gonorrhea, VDRL, Chlamydia and Pap Smear

These tests are to be performed when, in the judgment of the PCP, they are appropriate. Adolescents should be questioned about sexual activity and given assistance, diagnosis, treatment or information as the situation requires.

Bacteriuria

Tests for bacteriuria must be done on any child who has symptoms relating to possible urinary tract involvement. Routinely at every screen the simple Nitrate Test by dip stick is acceptable for bacteriuria testing. Although it is best done on a first morning specimen, it may be done on a random specimen. A single dipstick is available to test for albumin, sugar, and bacteria.

Immunizations

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

The U.S. Department of Health and Human Services' Centers for Disease Control and Prevention's (CDC) 2016 Recommended Childhood and Adolescent Immunization and Catch-up schedule as approved by the Department of Human Services (DHS) is located in the Appendix of the Manual and in the EPSDT section of the Provider Center at www.keystonefirstpa.com

Keystone First will reimburse for vaccines not provided under the Vaccines for Children Program (VFC) or vaccines administered to Members over the age of 18. When a vaccine is covered under the VFC Program, Keystone First will reimburse an administration fee only.

Pharmacy Services

Pharmacy Phone Number: 1-800-588-6767
Pharmacy Fax Number: 1-215-937-5018

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

All Members have prescription benefits. There may be a co-payment associated with certain medications. Please refer to the "Benefit Limit and Co-payment Schedule" in Section I of this Manual and at www.keystonefirstpa.com

Members can receive up to a 34-day supply or 150 units of a covered pharmaceutical product, whichever is less, per prescription order or refill. Select generic medications are eligible to be filled for a 90 day supply. Prescriptions written for greater than 150 units require authorization. Please refer to the "Pharmacy Prior Authorization Process" located in this Section of the Manual.

To provide a means of accessing their prescription drug benefit, Keystone First has formed a proprietary retail pharmacy Network. This business model allows Keystone First to directly credential, communicate with and audit both independent and chain pharmacies providing products and services to our Members.

Keystone First's Drug Formulary

The Keystone First drug benefit has been developed to cover Medically Necessary prescription products. The pharmacy benefit design provides for outpatient prescription services that are appropriate, Medically Necessary, and are not likely to result in adverse medical outcomes.

The Keystone First Formulary and Prior Authorization process are key components of the benefit design. The medications included in the Formulary are reviewed and approved by the Pharmacy and Therapeutics Committee and the Department of Human Services (DHS). The Pharmacy and Therapeutics Committee includes physicians and pharmacists actively participating in Keystone First as Network Providers. The goal of the Formulary is to provide clinically efficacious, safe and cost-effective pharmacologic therapies based on prospective, concurrent, and retrospective peer reviewed medical literature.

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

**Keystone First
Pharmacy and Therapeutics Committee
200 Stevens Drive
Philadelphia, PA 19113**

The most up-to-date Formulary is available online in the Provider Center at www.keystonefirstpa.com. Copies are available to Providers and Members upon request. Please contact the Keystone First Provider Services Department at **1-800-521-6007** to request additional copies of the Formulary.

Pharmacy Prior Authorization Process

To Obtain Prior Authorization:

The Pharmacy Services Department at Keystone First issues Prior Authorizations to allow processing of certain prescription Claims (more information on the types of drugs that require Prior Authorizations can be found later in this section) that would otherwise be rejected. To contact the Pharmacy Services Department by telephone, call **1-800-588-6767** between 8:30 a.m. and 6:00 p.m. Monday through Friday (EST); and after business hours, Saturday, Sunday and Holidays, the Member Services Department at **1-800-521-6860**. The Prior Authorization procedure is as follows:

- **The most efficient and fastest method is for the prescriber to submit the online Prior Authorization form under Pharmacy Services on www.keystonefirstpa.com.** Or, contacts Keystone First by telephone **1-800-588-6767**, in writing by fax **1-215-937-5018** to request Prior Authorization for non-Formulary, non-covered agents, or those designated pharmaceutical agents outlined in the Formulary as requiring Prior Authorization. The Member Services Department may be contacted for clinical issues after business hours, Saturdays, Sundays, and Holidays by telephone at **1-800-521-6860**
- Utilizing criteria approved by both Keystone First's Pharmacy and Therapeutics Committee and DHS, (hereafter referred to as "Approved Criteria"), a Keystone First pharmacist reviews the request
 - When the Prior Authorization request meets the Approved Criteria, the request is approved and payment for the prescription may be authorized for a period of up to twelve months, or for the length of the prescriber's request, whichever is shorter
- When the Prior Authorization request does not meet the Approved Criteria, the request is forwarded to a Keystone First Medical Director for review. In evaluating the request, the Medical Director generally relies upon information supplied by the prescribers, the Medical Director's medical expertise, guidelines published in the Physicians' Desk Reference, and accepted clinical practice guidelines.
- In the event of insufficient information provided by the prescriber, a Keystone First pharmacist will attempt to contact the prescriber to obtain the necessary clinical information for review. In addition, the decision will comply with the following statutory and regulatory requirements:
 - 55 Pa. Code 1121 (The Pennsylvania Code)
 - Medical Assistance Bulletin 03-94-03
 - The Social Security Act
 - OBRA '90 guidelines
 - Any other applicable state and/or federal statutory/regulatory provisions
- For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines:

That the prescriber did not make a good faith effort to submit a complete request, or that the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

To Request Ongoing Medication/Temporary Supplies:

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

- Keystone First will review all requests for Prior Authorization when a temporary 5-day or 15-day supply has been dispensed regardless of whether the prescriber formally submits a Prior Authorization request. For those requests that are approved by a Keystone First pharmacist, Keystone First will contact the prescribing provider by fax to inform him or her of the approval. The provider informs the Member of the approval.
- For those requests that cannot be approved by a Keystone First pharmacist, a Keystone First Medical Director will review each request and make and communicate a determination within 24 hours. In the event of a denial, Keystone First will notify the prescriber, the PCP and the Member by fax within 24 hours and will offer the prescriber a Formulary approved alternative. The correspondence will outline specifically all Member and Health Care Provider Appeal rights. If the request is approved by the Medical Director, Keystone First will notify the prescriber that the request has been approved.
- The prescriber or PCP may discuss Keystone First's decision with a Keystone First Clinical Pharmacist or Medical Director during regular business hours (Monday through Friday 8:30am- 6:00pm). For after-hours urgent calls, call the Member Services Department. To speak with a Keystone First Clinical Pharmacist or Medical Director, please call the Pharmacy Services Department at **1-800-588-6767**.
- Prescribers and Members may obtain Prior Authorization criteria related to a specific denial determination by submitting a written request for the criteria or by calling the Pharmacy Services Department.

Pharmacies have been made aware of the temporary supply requirements. If you become aware of a specific pharmacy that is not dispensing a temporary supply, please contact the Pharmacy Services Department at **1-800-588-6767**.

Drugs Requiring Prior Authorization

- All non-formulary medications
- All prescriptions that exceed plan limits
- All brand name medications with an available AB-rated generic equivalent (see exceptions under Generic Medications below)
- Limited use agents

- Regimens that are outside the parameters of use approved by the FDA or accepted standards of care
- Prescriptions that exceed \$500.00
- Self-injectable medications other than formulary insulin, glucagon, glucagon, haloperidol, haloperidol decanoate, fluphenazine, fluphenazine decanoate and Epipen.
- Prescriptions processed by non-network pharmacies
- Compounded prescriptions that exceed \$200
- Early refills

Please note: additional drugs in the Formulary require Prior Authorization; consult the Formulary for up-to-date Prior Authorization requirements. Any medication without specific prior authorization criteria is reviewed under the “Non-formulary Medication” criteria.

Injectable and Specialty Medications

Specialty drugs are a specific group of medications that include unusually high cost oral, inhaled, injectable or infused pharmaceuticals. These drugs are typically prescribed for a relatively narrow spectrum of diseases and conditions and are drugs that often require specific distribution and/or handling. Specialty medications include treatments covered under either the pharmacy benefit or the medical benefit. These products typically have very specific clinical criteria and prescribing guidelines that must be followed to ensure appropriate use and outcomes. Compliance with these criteria is managed through the Prior Authorization process. Unless otherwise specified, specialty drugs managed by the Keystone First Specialty Drug Program require Prior Authorization. Specialty drugs that are incidental to, and administered during an inpatient hospital or hospital-based clinic stay are not managed through Keystone First Specialty Drug Program and may not require Prior Authorization with the exception of Epogen (erythropoietin). Please refer to the "Epogen Policy" located in this section of the Manual. Exceptions include formulary insulin, glucagon, haloperidol, haloperidol decanoate, fluphenazine, fluphenazine decanoate and Epipen. Specific forms for specialty and injectable medications can be found online at www.keystonefirstpa.com/pharmacy.

The Specialty Drug Program focuses on those medications and treatments that represent a potential high health, economic, or safety impact to the patient. The goal of the program is to control and facilitate utilization and distribution of medication, resulting in improved patient outcomes and minimization of waste. Key aspects of this program are intensive clinical review based upon approved protocols for usage, specialty network management, electronic claims adjudication, and utilization management.

This program provides replacement of drugs administered in a physician’s office, and for specialty medications dispensed through Network specialty or retail pharmacies. Nurse Case Management for bleeding disorders, inpatient high cost drug carve-out management, and home infusion medication management are some of the focused-approach facets of this important clinical program. See “**Bleeding Disorders Program**” in this section of the Manual for additional information.

Health Care Providers should use the drug or class specific prior authorization request forms if available. The order form must be completed in its entirety and faxed to the Keystone First Specialty Drug Management Program at **1-215-937-5018**. Failure to submit all requested information could result in denial of coverage or a delay of approval as the result of insufficient information.

Providers should inform Keystone First members that specialty medications may not be available through a retail pharmacy and that designated specialty pharmacies should be utilized. Members can be directed to the member handbook and online for information about approved specialty pharmacies and a listing of specialty medications. Members have the right to choose any network specialty pharmacy to provide medication and other ancillary services.

The forms can be obtained by calling the Keystone First Specialty Pharmacy Services Department at **1-800-588-6767**. They can also be found online in the Provider Center at www.keystonefirstpa.com. Please feel free to copy these forms as needed. The forms are updated as needed so please check the website for the latest updates.

To speak to a Keystone First representative about the Specialty Drug Management Program, please call **1-800-588-6767**.

Bleeding Disorders Management Program Description

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

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

- Provide support to Members needing information and care regarding their disorder.
- Educates members and their families based upon recommendations provided by the Medical and Scientific Advisory Council (MASAC) through the National Hemophilia Foundation (NHF).
- Coordinates services for health care issues, by working with PCPs and other providers to ensure Members get timely needed care.
- Locates community resources; and function as a liaison between the Member, the specialty pharmacy Network, and the hemophilia treatment center/provider.
- Communicates with the Member's treating physician (and the Primary Care Physician if appropriate) when complications are identified that require intervention outside of the scope of the Bleeding Disorders Nurse Case Manager and documents these interactions accordingly in the appropriate system.
- Identifies problems/barriers to Keystone's Care Coordination Team for appropriate care management interventions.

REFERRAL & AUTHORIZATION REQUIREMENTS

- Assists the member in resolving care issues and/or barriers to services including, but not limited to pharmacy, equipment, PCP and Specialist physician access, outpatient services, home health care services and coordination of transportation for medical appointments.
- Is responsible for regular telephone contact and, if applicable, home site visits with the Member and/or treatment team.
- Aligns its goals and objectives with those of the Hemophilia Treatment Centers (HTC) to ensure continuity and acuity of care.
- Is available 24/7 to Specialty Pharmacies and members if needed.
- Ensure that factor dosage, and days of service are accurate.

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

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

The Procedure for Requesting Hemophilia Medications is as follows:

- Completed order request form (including current weight)
- Physician order/prescription (needed with every request)
- Administration/Bleed logs
- The Provider must submit a completed hemophilia factor order request form and a prescription from the doctor for all initial factor requests.
- The Specialty Pharmacy sends the request to PerformRx for review.
- Bleeding Disorder Nurse Case Manager Reviews and approved factor if approvable.
- Specialty Pharmacy timely delivers factor via UPS or other carrier.

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

Blood factor products that are subject to review include Factor VII (Novoseven), Factor VIII, Factor IX, Factor FXIII and Anti-Inhibitor Coagulant Complex. A four-week supply is typically approved for patients receiving prophylactic treatment. Medication may be approved on an as needed basis for patients requiring replacement medication or for treatment of episodic bleeding.

Delivery of approved products to Members is coordinated via authorized Specialty Pharmacy providers.

Epogen Policy

Keystone First's Claims Department will automatically adjudicate Claims for payment for cumulative monthly amounts of erythropoietin equal to or less than 50,000 units. Dialysis centers and/or physicians will be required to submit documentation to the Keystone First Specialty Drug Program to establish the medical necessity of cumulative monthly doses of erythropoietin **greater** than 50,000 units. With the exception of facilities contracted at a case rate for Epogen, units over these amounts require Prior Authorization and will be denied if they are billed without an authorization.

Once a specific dose is authorized, it will be approved for up to three months. Dosage increases will require additional Prior Authorization. The Prior Authorization request form is titled:

***REQUIRED DOCUMENTATION FOR APPROVAL OF MONTHLY
ERYTHROPOIETIN (EPOGEN®) DOSES GREATER THAN 50,000 UNITS***

The form can be obtained by accessing the Keystone First website at www.keystonefirstpa.com in the Provider Center or by calling the Keystone First Specialty Drug Program at **1-800-588-6767**.

Please check the website for the latest forms. Feel free to copy these forms as needed. Completed forms should be faxed to **215-937-5018**.

Generic Medications

The use of generic drugs in place of brand name products is mandated by the Commonwealth of Pennsylvania when the brand name product has an FDA approved AB-rated generic equivalent available. When an approved generic equivalent is available, all prescriptions denoting "Brand Necessary" require Prior Authorization. A Health Care Provider requesting a brand product under these circumstances must include information to substantiate medical necessity for a brand medication, such as documentation of adverse effects of generic alternatives. A limited number of brand name products are excluded from the above Prior Authorization requirement, and include the following NTI (Narrow Therapeutic Index) drugs:

- Thyroid preparations
- Phenytoin
- Digoxin
- Carbamazepine
- Lithium
- Sustained Release Theophylline
- Warfarin

Over-the-Counter Medication

Certain generic over-the-counter medications are covered by Keystone First with a prescription from the prescribing Health Care Provider, including:

REFERRAL & AUTHORIZATION REQUIREMENTS

- Analgesics such as aspirin, acetaminophen and non-steroidal anti-inflammatory drugs
- Antacids
- Anti-diarrheals such as loperamide and kaolin-pectin combinations
- Anti-flatulents such as simethicone
- Antihistamines
- Antinauseants
- Bronchodilators
- Cough and cold preparations (members older than 2 years of age)
- Contraceptives
- Hematinics not including long-acting products
- Insulin
- Laxatives and stool softeners
- Nasal preparations
- Ophthalmic preparations
- Single and multiple ingredients topical products such as antibacterials, anesthetics, anti-fungals, dermatological baths, rectal preparations, tar preparations (excluding soaps, shampoos, and cleansing agents), wet dressings, scabicides, corticosteroids (such as hydrocortisone 1% for rashes), and benzoyl peroxide.
- Single and multiple vitamins with and without fluoride are covered for Members younger than twenty-one (21) years of age when Medically Necessary
- Oral electrolyte mixtures
- Prenatal vitamins
- Tobacco cessation products

Vitamin Coverage

Keystone First covers store brand vitamins for Members eligible for pharmacy benefits if Medically Necessary. Members must have a written prescription from a Health Care Provider to get them. The following vitamins are covered:

- Generic single entity and multiple vitamin preparations with or without fluoride for children less than 21 years of age
- Vitamin D and its analogs; nicotinic acid and its analogs; Vitamin K and its analogs; folic acid for Members 21 years of age and older
- Generic prenatal vitamins for pregnant female patients only.

Blood Glucose Monitors

Blood glucose monitors made by Roche®, selected Accu-Chek products are covered with a prescription for Keystone First Members with diabetes.

Meters, strips, lancets and control solution may be prescribed for members with diabetes and filled at all participating network pharmacies. Pregnant Members and Members being managed on insulin, GLP-1 agonists or amylin analogs products are eligible for 100 strips per month. Members being managed on oral products (non-insulin users) are eligible for 50 strips per month.

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

Medication Covered by Other Insurance

As an agent of the Commonwealth of Pennsylvania Medical Assistance Program, Keystone First is always the payor of last resort in the event that a Member receives medical services or medication covered by another payor source. All Claims where there are third-party resources must first be billed to the primary insurer. Claims for the unpaid balance should then be billed to Keystone First.

Non-Covered Medications

The following are non-covered medications under the MA Program, and therefore not covered by Keystone First:

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

Information Available on the Web

The following reference materials are available in the Provider Center on the Keystone First website: www.keystonefirstpa.com

- Keystone First Searchable Formulary
- Keystone First Online Prior Authorization request form
- Drug Specific Physician Injectable Drug Replacement Order forms
- Physician Chemotherapy Drug Replacement Order form
- Patient Self-Administered Injectable and Specialty Drugs Request form

Podiatry Services

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

Podiatry Services/Orthotics

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

Provider Preventable Conditions Payment Policy

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

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of Medicare's hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

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

For a list of PPCs for which Keystone First will not provide reimbursement, please refer to the Appendix of this Manual.

Submitting Claims Involving a PPC

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

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

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

Practitioner/Dental Providers

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

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

Claim Type:

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

Claim Format:

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

Inpatient/Outpatient Facilities

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

For Inpatient facilities

REFERRAL & AUTHORIZATION REQUIREMENTS

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired. When submitting a claim which includes treatment as a result of a PPC, facility providers are to include the appropriate ICD10 diagnosis codes, including applicable external cause of injury codes on the claim in field 67 A – Q. Examples of ICD-10 and diagnosis codes include:

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

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

Medical Claim Review
c/o Keystone First
PO Box 7304
London, KY 40742

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

For Outpatient Providers

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

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

Reporting a Present on Admission PPC

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

Valid POA indicators are as follows:

“Y” = Yes = present at the time of inpatient admission

“N” = No = not present at the time of inpatient admission

“U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission

“W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not

“null” = Exempt from POA reporting.

Recipient Restriction Program

It is the function of DHS's Bureau of Program Integrity and Keystone First to identify Members who have misused, abused or committed possible Fraud in relation to the MA Program.

DHS's Bureau of Program Integrity and Keystone First have established procedures for reviewing Member utilization of medical services. The review of services identifies Members receiving excessive or unnecessary treatment, diagnostic services, drugs, medical supplies, or other services. A Member is subject for review if any of the following criteria are satisfied:

- Member gets prescriptions filled at >2 pharmacy locations within one month
- Member has prescriptions written by >2 physicians per month
- Member fills prescriptions for > than 2 controlled substances per month
- Member obtains refills (especially on controlled substances) before recommended days' supply is exhausted
- Duration of narcotic therapy is > 30 consecutive days without an appropriate diagnosis
- Prescribed dose outside recommended therapeutic range
- Same/Similar therapy prescribed by different prescribers
- No match between therapeutic agent and specialty of prescriber
- Fraudulent activities (forged/altered prescriptions or borrowed cards)
- Repetitive emergency room visits with little or no PCP intervention or follow-up
- Same/Similar services or procedures in an outpatient setting within one year

Keystone First receives referrals of suspected Fraud, mis-utilization or abuse from a number of sources, including physician/pharmacy providers, the Plan's Pharmacy Services Department, Member/Provider Services, Special Investigations Unit, Case Management/Care Coordination, Special Care Unit, Quality Assurance and Performance Improvement, Medical Affairs and the Department of Human Services (DHS). Network Providers who suspect Member fraud, misuse or abuse of services can make a referral to the Recipient Restriction Program by calling the Keystone First Fraud and Abuse Hotline at **1-866-833-9718**. All such referrals are reviewed for potential restriction.

If the results of the review indicate misuse, abuse or Fraud, the Member will be placed on the Recipient Restriction Program, which means the Member(s) can be restricted to a PCP, pharmacy and/or hospital/facility for a period of five (5) years. Restriction to one Network Provider of a particular type will ensure coordination of care and provide for medical management.

The PCP office will receive a letter from Keystone First identifying the restricted recipient's name and Keystone First ID number, and, as appropriate, the pharmacy where the recipient must receive his/her prescription medications, and/or the name of the hospital where the recipient must receive elective health care services.

The Member will also receive a letter outlining the restriction. The Member has the right to appeal the restriction. The restriction will follow the Member even if the Member leaves Keystone First for another Medical Assistance Plan. The Member can also request to be restricted to a PCP or hospital by calling Member Services.

In an emergency situation, the restricted Member may seek care at the nearest emergency room. The evaluating hospital will be notified of the Member's assigned inpatient hospital through the DHS Eligibility Verification System (EVS). In the event that a Member restricted to a specific hospital presents to the emergency room of a hospital other than the assigned inpatient hospital and the Member requires an inpatient admission, the Member must be transferred to his/her assigned inpatient hospital once the Member has been stabilized and, in the judgment of the treating physician, the Member is clinically stable for transfer. Please refer to the Hospital Transfer Policy.

For more information concerning the Recipient Restriction Program, please refer to applicable Medical Assistance regulations (55 Pa. Code § 1101.91 and § 1101.92) located in Section XII of this Manual.

Radiology Services

The following services, when performed as an **outpatient service**, require prior authorization by Keystone First's radiology benefits vendor, National Imaging Associates Inc. (NIA)

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

To request prior authorization contact Keystone First's radiology benefits vendor (NIA via their provider web-portal at www.radmd.com or by calling 1-800-642-2602 Monday through Friday 8 a.m. –8 p.m. (EST).

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

Weekend, Holidays and After-Hours Requests*

Requests can be submitted online – The NIA web site is available 24 hours a day to providers.

Weekend, holiday and after-hours requests for preauthorization of outpatient elective imaging studies may be called in to NIA and a message may be left (1-800-642-2602), which will be retrieved the following business day.

Requests left on voice mail:

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

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

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

Rehabilitation

If a Member requires extended care in a non-hospital facility for rehabilitation purposes, Keystone First's Utilization Management Department will provide assistance by coordinating the appropriate placement, thus ensuring receipt of Medically Necessary care. A Utilization Management Coordinator will conduct Concurrent and Retrospective Reviews for all inpatient rehabilitation cases. The Utilization Management Department can be reached at **1-800-521-6622**.

Reporting Communicable Disease

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

Termination of Pregnancy

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

1. The member's life is endangered if she were to carry the pregnancy to term; or
2. The pregnancy is the result of an act of rape or incest.

Life Threat

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

Rape or Incest

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

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

Vision Care

Vision Benefit Administrator

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

Corrective Lenses for Children (Younger Than 21 Years of Age):

Members younger than 21 years of age are eligible for two routine eye examinations every calendar year, or more often if Medically Necessary. No referrals are needed for routine eye exams. Members are also eligible to receive two pairs of prescription eyeglasses, every 12

REFERRAL & AUTHORIZATION REQUIREMENTS

months, or more often if Medically Necessary. Prescription contact lenses may also be chosen for Members younger than 21 years of age.

If the prescription eyeglasses are lost, stolen or broken, Keystone First will pay for them to be replaced, if approved. Please contact Davis Vision's Provider Relations Department at **1-800-773-2847** to obtain an approval. Lost, stolen or broken prescription contact lenses will be replaced with prescription eyeglasses.

- Members may choose from two select groups of eyeglass frames at no charge; or
- They may choose from a select group of premier eyeglass frames for a co-payment of \$25.00; or
- They may choose eyeglass frames that are not part of the select groups and Keystone First will pay a portion of the cost, up to \$40.00, whichever is less.
- If prescription contact lenses are chosen, Keystone First will pay for the cost of the prescription lenses or \$75.00, whichever is less.

There are special provisions for Members with aphakia, cataracts and diabetes. Please refer to "Eye Care Special Provisions" topic below.

Eye Care Benefits for Adults (21 Years of Age and Older):

Routine eye exams are covered twice every calendar year, and a co-pay may be applicable.

Members may receive up to two additional eye exams if the eye doctor completes a form.

Keystone First does not cover prescription eyeglasses or prescription contact lenses for Members 21 years of age and older with the exception that there are special provisions for Members with aphakia, cataracts and diabetes.

These Eye Care Special Provisions are:

- If a Member has aphakia, he or she is eligible to receive two pairs of prescription eyeglasses or prescription contact lenses per year. The full cost of the prescription contact lenses will be covered at no cost.
- If the Member has cataracts, he or she may receive prescription eyeglasses.
- If the Member has a diagnosis of diabetes (excluding gestational or pre-diabetes) he or she may receive frames and eyeglasses once every twelve months or in lieu of eyeglasses the cost of prescription contact lenses up to \$75.00.

Keystone First recognizes that optometrists are able to provide all services within the scope of their practice that are covered by the Pennsylvania Medical Assistance program, including benefit limits, category of aid restrictions as determined by Keystone First. Optometrists may provide the following services:

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

(Please note that Members may self-refer for one routine eye exam per year. Keystone First covers therapeutic optometry services through Davis Vision (unless the optometrist is in an Ophthalmology group that bills through the Keystone First claims process). Contact Davis Vision at 1-800-7732847 for questions regarding covered services and prior authorization requirements.