Introduction

Keystone First

About Keystone First

Who We Are

Keystone First, is Pennsylvania's largest Medical Assistance (Medicaid) managed care health plan serving more than 400,000 Medical Assistance recipients in Southeastern Pennsylvania including Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Our Mission

We Help People:

Get Care
Stay Well
Build Healthy Communities

We have a special concern for those who are poor.

Our Values

Our service is built on these values:

Advocacy
Care of the Poor
Compassion
Competence
Dignity
Diversity
Hospitality
Stewardship

Provider Services 1-800-521-6007 www.keystonefirstpa.com

Keystone First

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

Important Keystone First Telephone Numbers

Department	Phone	Fax
24 Hour Nurse Line	866-431-1514	
Behavioral Health Services		
Bucks County (Magellan Behavioral Health)	877-769-9784	
Chester County (Community Care Behavioral Health)	866-622-4228	
Delaware County (Magellan Behavioral Health)	888-207-2911	
Montgomery County (Magellan Behavioral Health)	877-769-9782	
Philadelphia County (Community Behavioral Health)	888-545-2600	
Bright Start Maternity Program (Prenatal) Program	800-521-6867	800-405-7946
Case Mgt./Pathways HIV Program	800-573-4100	215-937-8100
ChildLine (DHS number to report suspected child abuse)	1-800-932-0313	
Clinical Sentinel Hotline	1-800-426-2090	
Concurrent Review UNITS	800-521-6622 (choose concurrent review prompt)	
Contracting Department	866-546-7972	
Credentialing Department	800-642-3510	215-863-5627
Dental Benefits	877-408-0878	
Discharge Notification	800-521-6622	215-937-7366
DME/Outpatient Therapy Unit	800-521-6622	215-937-5383
EDI Technical Support Unit	877-234-4271	
Change Healthcare Provider Support Line	877-363-3666	
EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Outreach Program	1-888-765-9569	215-863-6325
ER Hospital Admission	800-521-6622	888-800-9005
Home Infusion	800-521-6622	215-937-5322

Department	Phone	Fax
Injectable Management Program	877-693-8275 215-937-5015	877-693-8483
Keystone First Fraud & Abuse Hotline	866-833-9718	
Maternity Data	800-521-6622	215-937-7325
Medical Assistance Transportation Program (MATP)	MATP County Numbers (refer to page 34)	
Medical Director Hotline	877-693-8480	
MEDTOX	1-800-FOR LEAD	
Member Services Department	800-521-6860	
NaviNet Customer Service	1-888-482-8057	
NIA (Outpatient Radiology Services)	1-800-642-2602	
Outreach & Health Education Programs	800-521-6007	
Pennsylvania Eligibility Verification System	800-766-5387	
Pennsylvania Tobacco Cessation Information	800-784-8669	
Pharmacy Services/Prior Authorization Department	800-588-6767	215-937-5018
Prior Authorization	800-521-6622	215-937-5322
Provider Claim Services Unit	800-521-6007	215-863-5735
Provider Network Management	800-521-6007	215-937-5343
Provider Services Department	800-521-6007	
Quality Assurance and Performance Improvement	215-937-8612	215-937-8270
Special Needs Case Management	800-573-4100	215-937-8100
Transportation Unit	800-521-6860	
TTY - Telecommunications for the Hearing Impaired	800-684-5505	
Utilization Management (Main Toll Free Number) *Direct Dial Team Numbers*:	800-521-6622	215-937-8012

Department	Phone	Fax
Unit 1	800-521-6622	215-937-7368
Unit 2	800-521-6622	215-937-7370
Unit 3	800-521-6622	215-937-7369
Unit 4	800-521-6622	215-937-7365
Maternity Data	800-521-6622	215-937-7325
Discharge Notification	800-521-6622	215-937-7366
Vision Benefit Administrator (Davis Vision)	800-773-2847	800-933-9375

Important Definitions

ACCESS Card	An identification card issued by the Department of Human Services (DHS) to each individual eligible for Medical Assistance (MA). The card is used by Providers to verify the individual's MA eligibility and specific covered benefits. .
Behavioral Health Managed Care Organization (BH-MCO)	An entity directly operated by the county government or licensed by the Commonwealth as a risk-bearing Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), which manages the purchase and provision of behavioral health services under a contract with DHS.
Capitation	A fixed per capita amount that Keystone First pays monthly to a Network Provider for each Member identified as being in their capitation group, whether or not the Member received services.
Care Management Services	Services which will assist individuals in gaining access to necessary medical, social, educational and other services.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.
Certified Nurse Midwife	An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. 171-176.
Certified Registered Nurse Practitioner (CRNP)	A registered nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.
Claim	A bill from a provider of a medical service or product that is assigned a claim reference number. A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.
Clean Claim	A Claim that can be processed without obtaining additional information from the provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the MCO's Claims system. Claims under investigation for Fraud or abuse or under review to determine if they are Medically Necessary are not Clean Claims.

Client Information System (CIS)

DHS's database of Members. The database contains demographic and eligibility information for all Members.

Complaint

A dispute or objection regarding a Network Provider or the coverage, operations, or management policies of a Physical Health Managed Care Organization (PH-MCO), which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department. A Complaint may arise from circumstances including but not limited to:

- a denial because the requested service/item is not a covered benefit; or
- a failure of the PH-MCO to meet the required time frames for providing a service/item; or
- a failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames; or
- a denial of payment by the PH-MCO after a service has been delivered because the service/item was provided, without authorization by the PH-MCO, by a Health Care Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- a denial of payment by the PH-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Member.

The term does not include a Grievance.

Concurrent Review

A review conducted by Keystone First during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether a different service or lesser level of service is Medically Necessary.

County Assistance Office (CAO)

The county offices of DHS that administer all benefit programs, including MA, on the local level. Department staff in these offices performs necessary functions such as determining and maintaining recipient eligibility.

Cultural Competency

The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Denial of Services

Any determination made by Keystone First in response to a request for approval, which: disapproves the request completely; or approves provision of the requested services, but for a lesser amount, scope or duration than requested; or disapproves provision of the requested services, but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service, which includes a requirement for a Concurrent Review by Keystone First during the authorized period, does not constitute a Denial of Services.

Denied Claim

An Adjudicated Claim that does not result in a payment to a Provider.

Department

The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

Developmental Disability

A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.
- Manifested before the individual attains age twenty-two (22).
- Likely to continue indefinitely.
- Manifested in substantial functional limitations in three or more of the following areas of life activity:
    - Self-care
    - Receptive and expressive language
    - Learning
    - Mobility
    - Capacity for independent living, and
    - Economic self-sufficiency
- Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in Developmental Disabilities if services are not provided.

Disease Management

An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Dispute	A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.
Dual Eligibles	An individual who is eligible to receive services through both Medicare and Keystone First (Medicaid). Dual Eligibles age twenty-one (21) and older, and who have Medicare, Part D, no longer participate in HealthChoices.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).
Early Intervention System	The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.
Eligibility Period	A period of time during which a Member is eligible to receive benefits. An Eligibility Period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date signifies an open-ended Eligibility Period.
Eligibility Verification System (EVS)	An automated system available to Providers and other specified organizations for automated verification of Members' current and past (up to three hundred sixty-five [365] days) MA eligibility, PH-MCO enrollment, PCP assignment, Third Party Resources, and scope of benefits.
Emergency Medical Condition	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
Emergency Services	Covered inpatient and outpatients services that: • Are furnished by a Health Care Provider that is qualified to furnish such service under Title XIX of the Social Security Act; and • Are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any health care service provided to a Member regardless of whether it has an associated Claim. A Claim form must be created and submitted to Keystone First for all Encounters, whether reimbursed through Capitation, fee-for-service, or another method of compensation.
Enrollee	A person eligible to receive services under the MA Program in the Commonwealth of Pennsylvania and who is mandated to be enrolled in the HealthChoices Program.
Enrollment	The process by which a Member's coverage is initiated.
Expanded Services	Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C.A. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to Members.
Experimental Treatment	A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.
Family Planning Services	Services that enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.
Federally Qualified Health Center (FQHC)	An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.
Formal Provider Appeals	A Formal Provider Appeal is a written request from a Health Care Provider for the reversal of a denial by Keystone First, through its Formal Provider Appeals Process. Types of issues addressed

through Keystone First's Formal Provider Appeals Process are:

- Denials based on medical necessity for services already rendered by the Health Care Provider to a Member, including denials that:
  - Do not clearly state the Health Care Provider is filing a Member Complaint or Grievance on behalf of a Member (even if the materials submitted with the Appeal contain a Member consent) or
  - Do not contain a Member consent that conforms with applicable law for a Member Complaint or Grievance filed by a Health Care Provider on behalf of a Member
- Disputes, other than claims related issues that are not resolved to the Network Provider's satisfaction through Keystone First's Informal Provider Dispute Process.

Formal Provider Appeals do not include: (a) Claims denied because they were not filed within the 180-day filing time limit; (b) denials issued through the Prior Authorization process; (c) credentialing denials for any reason; and (d) Network Provider terminations based on quality of care or other for cause reasons.

Formulary — An exclusive list of drug products for which Keystone First provides coverage to its Members, as approved by DHS.

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including a contractor, a subcontractor, a Health Care Provider, a State employee, or a Member, among others.

Grievance — Requests to have Keystone First reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A Grievance may be filed regarding Keystone First's decision to: 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level or service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item, but approve an alternative service/item. The term does not include a complaint.

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the

	Commonwealth (or state(s) in which the entity or person provides services), including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A federal law (Public Law 104-191) and its accompanying regulations enacted to, among other things, improve the portability and continuity of health insurance, combat waste, fraud, and abuse in health insurance and health care delivery, and simplify the administration of health insurance through the development of standards for the electronic exchange of health care information and protecting the security and privacy of personally identifiable health information.
Health Maintenance Organization (HMO)	A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members.
HealthChoices Program	The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to MA recipients.
Intermediate Care Facility for the Mentally Retarded and Other Related Conditions (ICF/MR/ORC)	An institution (or distinct part of an institution) that: 1) is primarily for the diagnosis, treatment or rehabilitation for persons with Intellectual Disability or persons with other related conditions; and 2) provides, in a residential setting, ongoing evaluation, planning, twenty-four (24) hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her maximum capacity.
Juvenile Detention Center (JDC)	A publicly or privately administered, secure residential facility for: • Children alleged to have committed delinquent acts who are awaiting a court hearing; • Children who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and • Children who have been returned from some other form of disposition and are awaiting a new disposition (i.e., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).
Managed Care Organization (MCO)	An entity that manages the purchase and provision of physical or behavioral health services under the HealthChoices Program.

Medical Assistance (MA)

The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C.A 1396 et seq., and regulations promulgated there under, and 62 P.S. 101 et seq.

Medical Assistance Transportation Program (MATP)

A non-emergency medical transportation service provided to eligible persons who need to make trips to-from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

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. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under the Health Choices Agreement.

Member

An individual who is enrolled with Keystone First under the HealthChoices Program and for whom Keystone First has agreed to arrange the provision of physical health services under the

	provisions of the HealthChoices Program.
Intellectual Disability	An impairment in intellectual functioning which is lifelong and originates during the developmental period (birth to twenty-two (22) years). It results in substantial limitations in three or more of the following areas: learning, self-direction; self-care; expressive and/or receptive language; mobility; capacity for independent living; and economic self-sufficiency.
National Provider Identifier (NPI)	A unique identifier for every Health Care Provider on a national level. NPI's replace Provider Identification Numbers (PINs) assigned by Medicare, Medicaid and local carriers. NPI's will replace Provider Unique Physician/practitioner Numbers (UPINs). It is not a replacement of or substitution for Tax Identification or Drug Enforcement Administration (DEA) numbers.
Network	All contracted or employed Providers with Keystone First who are providing covered services to Members.
Network Provider	A Provider who has a written Provider Agreement with and is credentialed by Keystone First, and who participates in Keystone First's Provider Network to serve Members.
Non-Participating Provider	A Health Care Provider, whether a person, firm, corporation, or other entity, either not enrolled in the Pennsylvania MA Program or not participating in Keystone First's Network, which provides medical services or supplies to Keystone First Members.
Nursing Facility	A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MA Program and certified for Medicare participation. The provider types and specialty codes are as follows: • General - PT 03, SC 030 • County - PT 03, SC 031 • Hospital-based - PT 03, SC 382
Observation Care	Observation Care is a clinically appropriate Utilization Management designation for patient services, which include ongoing short term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services are covered only when provided by the order

	of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the Observation Care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient Observation services span more than 48 hours.
Out-of-Plan Services	Services that are non-plan, non-capitated and are not the responsibility of Keystone First under the HealthChoices Program comprehensive benefit package.
Physical Health Managed Care Organization (PH-MCO)	A risk-bearing entity which has an agreement with DHS to manage the purchase and provision of Physical Health Services under the HealthChoices Program.
Post-Stabilization Services	Medically Necessary non-Emergency Services furnished to a Member after the Member is stabilized following an Emergency Medical Condition.
Primary Care Case Management (PCCM)	A program under which the Department contracts directly with PCPs who agree to be responsible for the provision and/or coordination of medical services to MA recipients under their care.
Primary Care Practitioner (PCP)	A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a Member.
Prior Authorization	A determination made by Keystone First to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested services.
PROMISe™ Provider Identification Number (PPID Number)	A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

Provider	A person, firm or corporation, enrolled in the Pennsylvania MA Program, which provides services or supplies to Keystone First Members.
Provider Agreement	Any Department approved written agreement between Keystone First and a Provider to provide medical or professional services to Keystone First Members.
Quality Assurance and Performance Improvement	An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.
Retrospective Review	A review conducted by Keystone First to determine whether services were delivered as prescribed and consistent with Keystone First's payment policies and procedures.
Sanction	An adverse action taken against a physician or allied health professional's participating status with Keystone First for a serious deviation from, or repeated non-compliance with, Keystone First's quality standards, and/or recognized treatment patterns of the organized medical community.
Short Procedure Unit (SPU)	A facility that can be a hospital or free standing unit that performs diagnostic or surgical procedures which do not require an overnight stay. A SPU procedure includes up to 23 hours of post procedure assessment and medical follow up care to assure the recovery of the Member for a safe discharge from the facility.
Special Needs	The circumstances for which a Member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DHS.
Subcontract	Any contract between Keystone First and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of Keystone First's responsibilities under the HealthChoices Program.
Third Party Liability (TPL)	The financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than Keystone First.
Title XVIII (Medicare)	A federally-financed health insurance program administered by the

Title XVIII (Medicare)	Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C.A. 1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.
Transitional Care Home	A tertiary care center that provides medical and personal care services to children upon discharge from the hospital that require intensive medical care for an extended period of time. This transition allows for the caregiver to be trained in the care of the child, so that the child can eventually be placed in the caregiver's home.
United States	As used in the context of payment for services or items provided outside of the United States, the term "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. The definition shall be updated when indicated in order to remain consistent with the Social Security Act.
Urgent Medical Condition	Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The terms also include situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.
Utilization Management	An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.
Vaccine For Children (VFC)	The Pennsylvania Department of Health's Vaccines for Children Program provides vaccines to children who are Medicaid eligible or do not have health insurance and to children who are insured but whose insurance does not cover immunizations (underinsured). These vaccines are to be given to eligible children without cost to the Provider or to the Member. All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program.