Keystone First

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2020 Keystone First Provider Manual Updates	Page
Definition Section - Updates/additions/clarification to the following definitions: Abuse, Complaints, Disputes (Informal Provider Disputes), Formal Provider Appeals (Provider Appeal), Grievance, Intellectual Disability, Provider, Retrospective Review and Third Party Liability	Definition Section
Deleted Home Modifications from Services Not Covered	24
Added the 2020 Member Copayment Schedule	25
Added Home Modification to services requiring Prior Authorization	36
Added language indicating that a network providers and other Providers can not deny covered services due to Member's inability to pay a copay, but may continue to attempt to collect the copay.	37, 217
Added language and contact information for reporting abuse/neglect of members ages 18-59	46
UM Inpatient Stay Monitoring - added that Keystone First must receive all clinical receive on the inpatient stay every 5 days which allows for decision and appropriate management of care.	51
Emergency Services Provided by Non-Participating Providers - clarification of no requirement for out-of-state and non-participating providers operating under single case agreements to be enrolled in the PA MA Program before payment can be made. Also language was added indicating that DHs may make a determination to require non-participating or out-of-state provider to convert to in-network status.	51, 140, 218
Blood pressure monitors less that $80 are covered under the KF pharmacy benefit.	56
Updated and clarified Nursing Facility Coverage and timing responsibilities	59 and 104
Updated EPSDT age screening requirements	65
Added EPSDT primary diagnosis codes	67
Clarified that the referral code YO is to be used to indicate Developmental Delay	68
Pharmacy Services - section revised/updated to reflect that Keystone First adheres to the Pennsylvania Department of Human Services (DHS) statewide preferred drug list (PDL) for drugs and classes that are included. Medication classes that are not included in the state PDL are reviewed and approved by the Keystone First's Pharmacy and Therapeutics Committee.	78-87

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Member Access Card name has been changed to: Pennsylvania (PA) Electronic Benefits Transfer (EBT) ACCESS Card	99 and 106
Monthly Panel List - deleted indication of mailing (available through NaviNet only). Stressed the importance of checking for members missing EPST screenings and adult preventive care visits.	100
Updated information available on the Member Clinical Summary report in NaviNet	110
PCP/OB GYN Office Standards - deleted the requirement to have a 3 year site visit re-evaluation.	135
Medical Record Retention - changed requirement from maintaining from 5 years to a minimum of 10 years.	137
Section VI - Changed name of section to Claims only. Moved all Claims Disputes instructions and definitions to Section VII	Section VI
Updated DHS Self-Audit tool link	146
Updated definitions of Fraud and Abuse	146-147
Section VII - updated definition of a Dispute and process to file a Dispute	156-157
Deleted the criteria that indicated that a First Level Appeal could not be related to a claims issue.	160
Outlined what the provider will received in an acknowledgement letter for a First Level Appeal	160
Clarified the role of the Physician doing a First Level Appeal - is conducted by a board certified Physician employed by Keystone First who was not involved in the decision making for the original denial or prior appeal review of the issue	160
Second Level Appeal- Outlined what the provider will received in an acknowledgement letter for a Second Level Appeal	162
Clarified the role of the Physician doing a Second Level Appeal - An external board certified Physician, who is contracted but not employed by Keystone First who was not involved in the decision making for the original denial or prior Appeal review issue will review the appeal.	162
Clarified next steps in Second Level Appeal review; required makeup of appeal panel and review/decision process.	162
Member Complaints, Grievances and Fair Hearings - 1. Updated definition to included the language of "regarding an adverse benefit determination" 2. Clarified that item (a) does not include a Benefit Limit Exception (BLE) and 3. added definition of a complaint without an adverse benefit determination.	163
Changed the days required to give a Member advance written notice of First Level Complaint Review from 7 to 10 days.	164
Under #10; added subsection a and b to further define requirements of the Committee.	164

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Grievance Process - Changed the days required to give a Member advance written notice of Grievance Review from 7 to 10 days	169
Under #8; added subsection a and b to further define requirements of the Committee.	169
Credentialing/Recredentialing requirements - Deleted Physician Assistant	185
Updated Provider Credentialing Rights for correcting erroneous information	188
Credentialing address changed from 200 Stevens Drive to 1 International Plaza	188, 190
Time table of UM decisions - concurrent review notifications; changed from 24 hours to 1 business day.	198
Physician Reviewer availability to discuss medical necessity decisions - a Provider can call to discuss; changed from 2 business days to 5 business days. Outlined the intake process and Physician Reviewer response time.	199
Integrated Health Care Management department has changed name to Population Health	202
Post partum home visit time frame - changed to ensure that both home visits are completed between day 7 and day 84 post-delivery	205
Rapid Response and Outreach Team - added the ability to help with social determinants of health situations	206, 207
Updated Member Rights and Responsibilities	212-214