

Wrap-Around Coverage Table 2020
¹Coordination of Medicaid with Medicare
Puerto Rico Health Insurance Administration (PRHIA)
Medicare Platino Program

<i>COVERAGE ORIGINAL MEDICARE</i>	<i>PLATINO WRAP STATE PLAN (Limited to the State Plan Covered Services)</i>
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INPATIENT HOSPITAL SERVICES *Co-Payment Code* **100-\$0.00 / 110-\$4.00 / 120- \$5.00 / 130- \$8.00**

Medicare Part A. **Covers Hospitalization care.** Covers hospital services, including semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care.

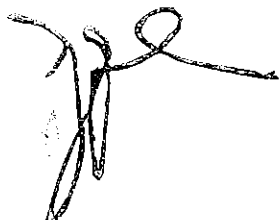
Costs in Original Medicare: Part B Medicare is responsible for the costs of that inpatient stay.

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

Coverage includes:

- Isolation room for medical reasons.
- Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized.
- Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy.

Blood: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated Complex (Auto flex and Feiba) per authorization of a certified hematologist.


INPATIENT HOSPITAL FOR MENTAL HEALTH DISEASES Co-Payment Code 100-\$0.00 / 110-\$4.00 /120- \$5.00 /130- \$8.00

Medicare Part A Covers Hospital inpatient Mental Health. Covers your room, meals, and nursing care. Medicare limited 190 days lifetime limit in psychiatric hospital.

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

INPATIENT SUBSTANCE USE DISORDER Co-Payment Code 100-\$0.00 / 110-\$4.00 /120- \$5.00 /130- \$8.00

Medicare Part A. **Covers Inpatient Substances Abuse.** Covers medically necessary inpatient substance abuse treatment services can be covered in Medicare certified hospital. Services provided in facilities that are not Medicare certified are not covered by Medicare.

Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage, and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.

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OUTPATIENT SUBSTANCE USE DISORDER Co-Payment Code 100-\$0.00 / 110-\$1.00 /120- \$1.50 /130- \$2.00

Medicare Part B **Covers Partial Hospitalization.**

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act).

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence

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of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization.

According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

OUTPATIENT MENTAL HEALTHCARE
& PROFESSIONAL SERVICES

Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00

Medicare Part B **Cover Mental Health Services and Visits**. Covers with these types of health professionals (deductibles and coinsurance may apply): Psychiatrist or other doctor, Clinical psychologist, Clinical social worker, Clinical nurse specialist, Nurse practitioner and Physician assistant, One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use.

- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services.
- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "self-administered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.

All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.



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- Partial hospitalization.
- A one-time “Welcome to Medicare” preventive visit. This visit includes a review of your potential risk factors for depression.
- A yearly “Wellness” visit. This is a good time to talk to your doctor or other health care provider about changes in your mental health so they can evaluate your changes year to year.

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LABORATORY AND HIGH TECH LABORATORIES Co-Payment Code 100-\$0.00 / 110-50¢ / 120- \$1.00 / 130- \$1.50

Medicare Part B **Covers Clinical Diagnostic Laboratory Services.** Covers that are ordered by your doctor or practitioner. Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests. They must be provided by a laboratory that meets Medicare requirements.

Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.

Medicare doesn't cover most Health Certificates

EPSDT UNDER 21 YEARS Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Medicare doesn't cover most EPSDT

EPSDT requirements non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

EPSDT Checkups must include all of the following:

A comprehensive health and developmental history; Developmental assessment, including mental, emotional, and Behavioral Health development; Measurements (including head circumference for infants); An assessment of nutritional status; A comprehensive unclothed physical exam; Immunizations according to the guidance issued by the Advisory Committee on Immunization Practices



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	(ACIP) (the vaccines themselves are provided and paid for by the Health Department for the Medicaid and CHIP Eligible. Certain laboratory tests; Anticipatory guidance and health education; Vision screening; Tuberculosis; Hearing screening; and Dental and oral health assessment. (Reference must be made to the corresponding CMS EPSDT guidelines and ASES policy).
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<i>COVERAGE ORIGINAL MEDICARE</i>	<i>PLATINO WRAP STATE PLAN</i>
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FAMILY PLANNING Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Medicare doesn't cover Family Planning

Family Planning services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provide voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations:

- Contra-indication with drugs that the Enrollee is already taking, and no other methods



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	<p>covered/available that can be used by the Enrollee.</p> <ul style="list-style-type: none"> • History of adverse reaction by the Enrollee to the contraceptive methods covered. • History of adverse reaction by the Enrollee to the contraceptive medications that are covered.
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TOBACCO CESSATION Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Medicare Part B (Medical Insurance) covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.

Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.

MATERNITY SERVICES Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00

Maternity Services
 Medicare Part A and B Covers Prenatal and Maternity Care. Covers medically necessary services and Inpatient services

Abortions are only covered when the life of the mother would be in danger if the fetus is carried to term.

Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Abortions when the pregnancy is a result of rape or incest as certified by a physician.

Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term as certified by a physician.

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MEDICAL AND SURGICAL Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00



<p>Medicare Part B Covers Ambulatory Surgery. Covers the facility and professional service fees related to approve surgical procedures provided in an ambulatory surgical center.</p>	<p>Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.</p> <p>Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form included as Appendix (O) (18) of the Contract.</p>
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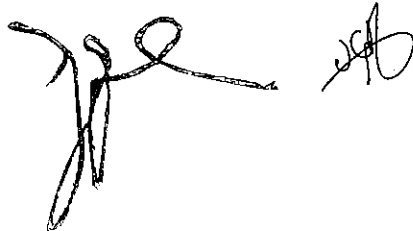
VISION SERVICES *Co-Payment Code* 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00

<p>Medicare Part B - Medicare does not normally cover routine vision services, such as eyeglasses and eye exams. Covers Glaucoma Tests every 12 months under certain circumstances. For people with diabetes: It covers eye exam to check for diabetes retinopathy.</p>	<p>Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.</p> <p>Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when medically necessary will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be pre authorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.</p>
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DENTAL SERVICES PREVENTIVE & RESTORATIVE

Co-Payment Code

Preventive (Child)100-\$0.00 / 110-\$0.00 /120- \$0.00 /130- \$0.00
Preventive (Adult)100-\$0.00 / 110-\$1.00 /120- \$1.50 /130- \$2.00
Restorative 100-\$0.00 / 110-\$1.00 /120- \$1.50 /130- \$2.00




Medicare doesn't cover most dental care, Part A can pay for inpatient hospital care to have emergency or complicated dental procedures, even though the dental care isn't covered

Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

The following are the benefits included in the GHP;

- All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement
- Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21);
- Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy;
- Preventive dental services for Adults;
- Restorative dental services for Adults;
- One (1) comprehensive oral exam per year;
- One (1) periodical exam every six months;
- One (1) defined problem-limited oral exam;
- One (1) full series of intra oral radiographies, including bite, every three (3) years.
- One (1) initial periapical intra-oral radiography;
- Up to five (5) additional periapical/intra-oral radiographies per year;
- One (1) single film-bite radiography per year;
- One (1) two-film bite radiography per year;
- One (1) panoramic radiography every three (3) years;
- One (1) adult cleanse every six (6) months;
- One (1) child cleanse every six (6) months;
- One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old;
- Fissure sealants for life for Enrollees up to fourteen (14) years old, including deciduous molars up to eight (8) years old when Medically Necessary because of cavity tendencies;
- Amalgam restoration;
- Resin restorations;
- Root Canal;
- Palliative treatment; and
- Oral Surgery



COVERAGE ORIGINAL MEDICARE	PLAIN WRAP STATE PLAN

HEARING EXAMS Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00

Medicare Part B Covers Diagnostic Hearing and balance exams if the physician or other health care provider orders these tests to see if you need medical treatment. Medicare covers audio logic diagnostic testing provided by an audiologist when a physician or non-physician practitioner (nurse practitioner, clinical nurse specialist, or physician's assistant) orders the evaluation for the purpose of informing the physician's diagnostic medical evaluation or

Hearing related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Hearing aids for beneficiaries over 20 years old are excluded from coverage. Refer to ESPDT for hearing cover services.



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determining appropriate medical or surgical treatment of a hearing deficit or related medical problem
Medicare doesn't cover, hearing aids, or exams for fitting hearing aids.

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PREVENTIVE SERVICES *Co-Payment Code 100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00*

Immunizations

Medicare Part B **Covers Normally covers one Immunizations** shot per: Influenza (Flu); Hepatitis B; and Pneumococcal shots. Also cover tetanus and rabies shots when expose or at risk episode.

Vaccines coverage according to the Medicare Benefit Package.

Immunization services non-covered by;

- 1- Medicare Part B.
- 2- MAO Part D drug formulary.
- 3- MAO supplementary plan benefits.
- 4- Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.

PHYSICAL, OCCUPATIONAL, SPEECH THERAPY *Co-Payment Code 100-\$0.00 / 110-\$1.00 / 120- \$1.50 / 130- \$2.00*

Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services.

Medicare law no longer limits how much Medicare pays for your medically necessary outpatient therapy services in one calendar year. However, your therapist will need to add information to your therapy claims and your medical record if your therapy services reach these amounts in 2018:

\$2,010 for physical therapy (PT) and speech-language pathology (SLP) services combined

Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.

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\$2,010 for occupational therapy (OT) services
Once your therapy services reach these amounts, your therapist will need to add a special code to your therapy claim. By adding this code, your therapist confirms that:

Your therapy services are reasonable and necessary

Your medical record includes information to explain why the services are medically necessary

A Medicare contractor may also review your medical records to be sure your therapy services were medically necessary. This review may happen if your therapy services reach these amounts in 2018:

\$3,000 for PT and SLP services combined

\$3,000 for OT services

Your therapist or therapy provider must give you a written notice before providing services that aren't medically necessary. This includes therapy services that are generally covered but aren't medically reasonable and necessary for you at the time. This notice is called an "Advance Beneficiary Notice of Non coverage" (ABN). The ABN lets you choose whether or not you want the therapy services. If you choose to get the medically unnecessary services, you agree to pay for them.

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PRESCRIPTION DRUGS



Wrap-Around Coverage Table 2020

Co-Payment Code	100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00	Preferred (Children 0-21)
Co-Payment Code	100-\$0.00 / 110-\$1.00 / 120- \$2.00 / 130- \$3.00	Preferred (Adult)****
Co-Payment Code	100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00	Non-Preferred (Children 0-21)
Co-Payment Code	100-\$0.00 / 110-\$3.00 / 120- \$4.00 / 130- \$6.00	Non-Preferred (Adult)****
Co-Payment Code	100-\$0.00 / 110-\$0.00 / 120- \$0.00 / 130- \$0.00	Outpatient Substance Abuse

Drugs and biologicals are covered only if all of the following are met: they meet the definition of drugs or biologicals; they are not the type that are usually self-administered; they meet all of the general requirements for coverage of items as incident to a physician's services; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; they are not excluded as immunizations; and they have not been determined by the FDA to be less than effective.

Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.

Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan

The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings:

- All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution.
- Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap-Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category.
- Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.



¹Medicare Platino cannot establish copayments higher than the ones specified in the Wrap Around table.

Platino wrap services are subject to the maximum co-payments in the table with exemptions and zero co-payments for Medicaid/CHIP beneficiaries and certain services as follows:

Medicaid/CHIP Beneficiaries

- Children from 0 to less than 21 years of age;
- Pregnant woman (during pregnancy and the 60-day post-partum period);
- American Indians and Alaskan Natives (AI/AN)
- Institutionalized Individuals; and
- Individuals receiving hospice care.

Services

- Emergency services, including ambulatory, hospital and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a);
- Family planning services and supplies;
- Preventative services provided to children less than 18 years of age
- Pregnancy related services and counseling and drugs for cessation of tobacco use;
- Provider-preventable services as defined in 42 CFR 447.26(b); and
- Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.

Notes: 1. Wrap around table is subject to change in 01/01/2020.

2. N/A= Medicare fulfill or exceeds PSG benefit

