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# UPMC *for You* (Medical Assistance)



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## *At a Glance*

UPMC *for You*, affiliate program of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in a 14-county service area. This care is achieved by combining the benefits of a managed care organization with all the services covered by Medical Assistance. All Health Plan providers must abide by the rules and regulations set forth under the General Provision of 55 Pa. Code, Chapter 1101.



### Alert—Department of Public Welfare Regulations

This manual may not reflect the most recent changes to Department of Public Welfare regulations. Updates will be provided periodically. Call Provider Services at 1-800-286-4242 and select option #3 or visit [www.upmchealthplan.com](http://www.upmchealthplan.com).

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If providers have questions regarding UPMC *for You* coverage, policies, or procedures that are not addressed in this manual, they may call Provider Services at 1-800-286-4242 from 8 a.m. to 5 p.m., Monday through Friday.

# *Medical Assistance Managed Care in Pennsylvania*

Pennsylvania's Department of Public Welfare (DPW) contracts with managed care organizations across Pennsylvania to offer managed care to recipients of Medical Assistance under two different programs: HealthChoices and Voluntary Managed Care.

## HealthChoices

HealthChoices is Pennsylvania's innovative mandatory managed care program for Medical Assistance recipients.

Recipients choose among physical health managed care organizations (PH-MCOs) contracted with the DPW to provide at least the same level of services as offered by ACCESS, the traditional fee-for-service program. Behavioral health services are provided by behavioral health managed care organizations that contract with a particular county, which in turn contracts with DPW. Greene County is an exception because it contracts directly with Value Behavioral Health.

UPMC *for You* participates in the HealthChoices program in southwestern Pennsylvania. The following counties are included in this zone:

- Allegheny
- Armstrong
- Beaver
- Butler
- Fayette
- Greene
- Indiana
- Lawrence
- Washington
- Westmoreland

In these counties, Medical Assistance recipients enroll in a PH-MCO, or change plans, with the assistance of an independent enrollment assistance representatives. Recipients also may call HealthChoices at 1-800-440-3989. TTY users should call 1-800-618-4225.

## Voluntary Managed Care

In some counties in Pennsylvania, managed care is a voluntary option for Medical Assistance recipients. In these counties, Medical Assistance recipients may choose to receive their benefits

either through ACCESS Plus, which is the traditional fee-for-service program, or from a managed care organization. Managed care organizations are required under their contracts with DPW to provide at least the same level of services offered to recipients through ACCESS.

Behavioral health services are covered by the ACCESS program and are coordinated through the member's behavioral health managed care organization.

Currently, UPMC *for You* offers the voluntary program option to Medical Assistance recipients in the following counties:

- Bedford
- Clearfield
- Crawford
- Mercer

In these counties, Medical Assistance recipients enroll in a PH-MCO, or change plans, by calling 1-800-485-5998. TTY users should call 1-800-618-4225.

At any time, UPMC *for You* members in these counties may opt out of the program and return to ACCESS Plus, or they may switch to another managed care organization contracted by DPW. Enrollment is coordinated by the independent enrollment assistance representative.

# Covered Benefits

## At a Glance

UPMC *for You* network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this manual, call Provider Services at 1-800-286-4242 from 8 a.m. to 5 p.m., Monday through Friday.



## Key Points

- 100 percent coverage for PCP visits
- 100 percent coverage for specialist visits when coordinated by a PCP
- 100 percent coverage for emergency services
- 100 percent coverage for prenatal care
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for persons under 21 years of age
- Coverage for all medically necessary services for members under 21

## Coordinated Care

The member's PCP must coordinate care. If the PCP refers a member to a network specialist and indicates diagnostic testing, the member should be directed to a network facility for that testing. A separate referral by the specialist is not required.

Upon notification by the member, family member, member's legal designee, or a hospital emergency department, the member's PCP must coordinate any care related to an emergency.

Members may self-direct their care for routine gynecological examinations, family planning, maternity care or prenatal visits, dental care, vision care, and chiropractic care.

Providers are responsible for assisting, when appropriate, in the coordination of services with the Behavioral Health MCO, including pharmacy coordination, to the extent permitted by law.

To verify the coverage of any service, please contact Provider Services at 1-800-286-4242 or visit [www.upmchealthplan.com](http://www.upmchealthplan.com).

All payments made to providers by UPMC *for You* constitute full reimbursement to the provider for covered services rendered. Please refer to the provider contract for specific fee schedules. In the event that UPMC Health Plan imposes copayments for certain covered services and a member cannot afford to pay said copayment, providers must render covered services to the member despite non-payment of the copayment by the member. This shall not preclude providers from seeking payment for said copayments from members after rendering covered services.

A provider may bill a UPMC *for You* member for a non-covered service or item only if, before performing the service, the provider informs the member:

- of the nature of the service;
- that the service is not covered by UPMC *for You* and UPMC *for You* will not pay for the service; and
- of the estimated cost to the member for the service.

The member must agree in writing that he or she will be financially responsible for the service.

### **Standards for Member Access to Services (Wait Time for Appointments)**

The Department of Public Welfare (DPW) standards require that members be given access to covered services in a timely manner, depending on the urgency of the need for services, as follows:

- A member's average office waiting time for an appointment for routine care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated urgent medical condition visit or is treating a member with a difficult medical need.

## Ambulance

Members do not need prior authorization for transportation related to emergency medical conditions.

All requests for medically necessary non-emergency transportation must be coordinated through UPMC Medical Transportation at 1-877-521-RIDE (7433) for the following:

- Air ambulance
- Ground ambulance
- Invalid coach
- Wheelchair van transportation



### Closer Look at Routine Medical Transportation

Providers should contact Medical Assistance Transportation Program (MATP) county offices to arrange for most routine non-emergency ambulance transportation for UPMC *for You* members. MATP requires 24 hour notice.

- ▶ See *Welcome and Key Contacts* chapter, *Medical Assistance Transportation Program*

*(MATP) County Offices, chapter A*

## Ancillary Services

The following ancillary services are covered when coordinated by a participating provider and rendered by a participating provider for medically necessary services covered by the Medical Assistance fee schedule. Some services may require prior authorization.

- Diagnostic services (e.g., lab, x-ray), including special diagnostics
- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides; and registered dietitian services)
- Home infusion therapy
- Home medical equipment (HME), including custom wheelchairs and rehabilitation equipment
- Hospice care
- Laboratory services
- Non-emergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Private duty nursing in the home (for members under age 21)
- Respiratory equipment, including oxygen therapy

## Chiropractic Care

UPMC *for You* members may self-direct to chiropractic care. Chiropractic services are covered when delivered by a network provider. UPMC *for You* covers only one evaluation per year and an unlimited number of medically necessary manual spinal manipulations. For children under the age of 13, the member's PCP should coordinate chiropractic services. Children 13 and under need prior authorization for chiropractic services.

UPMC *for You* will not cover x-rays when performed by a chiropractor; however, chiropractors may refer members to a network provider for x-rays.

## Dental Benefits

UPMC *for You* members may receive routine and emergency dental care. Benefits vary according to the member's Medical Assistance category.

Doral Dental Services of Pennsylvania administers routine and emergency dental benefits for UPMC *for You* members. Some members receive expanded dental services. Members may self-direct their dental care to a network provider.

Providers may call Doral directly at 1-800-341-8478.

Members may call Doral directly at 1-800-508-6775.

Members under 21 years of age receive dental screenings through the EPSDT program.

- ▶ See *The EPSDT Program*, chapter E.

## Diagnostic Services

These services include lab services, x-rays, and diagnostic tests. They are covered when ordered by a network provider and performed by a network ancillary provider.

Refer to the member's behavioral health vendor for coverage of diagnostic services related to mental health and substance abuse.

- ▶ See *Mental Health and Substance Abuse Benefits*, chapter E.

## Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

All EPSDT screens are covered for members under 21 years of age and are based on the EPSDT Periodicity Schedule.

- ▶ See *EPSDT Periodicity Schedule*, chapter E.

## Education

Members are eligible for the following health education classes:

- Breast-feeding
- Diabetes management
- Maternity
- Smoking cessation



### Closer Look at Education

Contact Special Needs at 1-800-286-4242 for information on education classes.

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## Emergency Care

UPMC *for You* will cover care for emergency medical conditions with 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 member (or, for pregnant women, the health of the woman or her unborn child) in serious jeopardy;

- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.



### Closer Look at Emergency Care

The hospital or facility must contact Medical Management at 1-800-425-7800 within 48 hours or on the next business day following an emergency admission.

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Members with an emergency medical condition or those acting on the member's behalf have the right to summon emergency help by calling 911 or any other emergency telephone number, or a licensed ambulance service, without getting prior approval from the member's PCP or from UPMC *for You*.

*Redirected Emergency Department Visits* PCPs should report all contact with UPMC *for You* members who have requested an emergency department visit. If a member is instructed to go to the office but, instead, goes directly to the emergency department and does not have an emergency medical condition, the visit may be considered a redirected emergency department visit and is subject to review on a case-by-case basis to determine the appropriate level of reimbursement. The PCP is required to notify Provider Services at 1-800-286-4242 within 24 hours.



#### Alert—Redirected Emergency Department Visit

Within 24 hours of redirecting an emergency department visit, the PCP must contact the member with any alternative care arrangements, such as an office visit or treatment instructions.

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## Family Planning

Members may self-direct care to network or out-of-network providers and clinics for family planning and birth control services.

## Hearing Exams/Aids

Exams require a PCP referral. Hearing aids are covered for UPMC *for You* members under 21 years when provided by a network provider.

## Home Health Care

Home health care services (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; and home health aides) are covered when coordinated through a network provider.

## Home Medical Equipment (HME)

Home medical equipment is covered when coordinated through a network provider and used

for medically necessary services that are on the Medical Assistance fee schedule.

▶ See *Quick Reference Guide*, chapter E.

## Home Physician Visits

Home physician visits are covered when provided by a network provider. Specialist visits require a referral from the member's PCP.

## Hospice Care

Hospice care is available for a terminal diagnosis with a prognosis of 6 months or fewer. This care must be coordinated through a network provider.

## Hospital Admissions

Members who fall into the adult and general assistance benefit categories will be subject to an inpatient hospital rehabilitation benefit limitation of one visit per state fiscal year (July 1 through June 30). Members in the general assistance benefit category will have an inpatient hospital acute care benefit limitation of one visit per state fiscal year.

UPMC *for You* members under the age of 21, pregnant, or in a nursing facility do not have any inpatient hospital service limits.

Please refer to [www.upmchealthplan.com](http://www.upmchealthplan.com) to review a member's individual schedule of benefits online, or call Provider Services at 1-800-286-4242.

Admissions to hospitals are covered if the provider and hospital facility obtain prior authorization from UPMC *for You* and if medically necessary. If a specialist admits the patient, the specialist should coordinate care with the member's PCP.

An exception to the inpatient hospital service limits may be granted if the UPMC *for You* member:

- Has a serious chronic illness or other serious health condition, and without the additional service the member's life would be in danger; or
- Has a serious chronic illness or other serious health condition, and without the additional service the member's health will get much worse; or
- Has to go into a nursing home or institution if the exception is not granted; or
- Needs a more costly service if the exception is not granted.

Providers may submit exception requests for inpatient hospital benefit limitations to the Medical Management department by calling 1-800-425-7800, faxing to 412-454-2057, or sending a letter to:

UPMC Health Plan  
Attn: Medical Management  
One Chatham Center

112 Washington Place  
Pittsburgh, PA 15219

A provider or the UPMC *for You* member must submit the following information to request an exception:

- Member's name
- Member's address and telephone number
- Member's UPMC *for You* member ID
  - A description of the service for which the provider or the member is requesting an exception
  - The reason the exception is necessary
- The provider's name and telephone number

A request for an exception may be made before or after the service has been delivered. For an exception request made before the service has been delivered, UPMC *for You* will respond within 21 days upon receipt of the request. If the provider indicates an urgent need for a quick response, UPMC *for You* will respond within 48 hours upon receipt of the request.

For an exception request after the service has been delivered, UPMC *for You* will respond within 30 days upon receipt of the request.

An exception request made after the service has been delivered must be submitted no later than 60 days from the date UPMC *for You* rejects the claim because the service is over the benefit limit. Exception requests made after 60 days from the claim rejection date will be denied.

Both the recipient and the provider will receive written notice of the approval or denial of the exception request. For exception requests made before the service has been delivered, if the provider or recipient is not notified of the decision within 21 days of the date the request is received, the exception will be automatically granted.

A provider may not hold the member liable for payment for services rendered unless:

- An exception to the limit has been requested and denied by UPMC *for You* **and** the member has been informed by the provider before the service was provided that the member will have to pay for the service if the exception is denied.

## Immunizations

PCPs and specialists serving UPMC *for You* members who are 18 years or younger need to be enrolled in Vaccines for Children (VFC), a federally funded program that provides vaccines free of charge. PCPs may provide other immunizations not covered under VFC but covered by UPMC *for You*. To verify the coverage, call Provider Services at 1-800-286-4242.

UPMC *for You* also covers certain adult immunizations. Call Provider Services at 1-800-286-4242 for more information.

## Medical Social Services

Coordinated social services provided by network hospitals and providers are covered.

UPMC *for You* and the provider must jointly address any identified social or personal need that affects a member's medical condition (e.g., lack of heat or water).

▶ See *Medical Management* chapter, *Special Needs Services*, chapter G.

## Mental Health and Substance Abuse Benefits

HealthChoices counties use different programs for coverage.

In Allegheny County, call Community Care Behavioral Health (CCBH) at 1-888-251-2224.

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### Closer Look at HealthChoices Counties

The following HealthChoices counties use Value Behavioral Health:

- Armstrong: 1-877-688-5969
  - Beaver: 1-877-688-5970
  - Butler: 1-877-688-5971
  - Fayette: 1-877-688-5972
  - Greene: 1-877-688-5973
  - Indiana: 1-877-688-5974
  - Lawrence: 1-877-688-5975
  - Washington: 1-877-688-5976
  - Westmoreland: 1-877-688-5977
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Behavioral health services are covered for members who reside in voluntary managed care counties (Bedford, Clearfield, Crawford, and Mercer). These services are coordinated through the member's behavioral health managed care organization.

## Office Visits

PCP visits are covered. Specialist visits are covered with a PCP referral.

## Organ Transplants

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Certain organ transplants are covered but require prior authorization from UPMC *for You*. Members must receive a referral from their PCP for specialist and diagnostic work-ups.

## Out-of-Area Care

Routine care performed outside the service area is not covered for UPMC *for You* members.

Care for an emergency medical condition that occurs out of the area is covered.

Members are encouraged to notify their PCPs after they receive such care.

Non-emergency services may be covered if:

- It is unreasonable to expect the member to return to the UPMC *for You* service area for treatment.
- Delay would result in a significant decline in the member's health. Urgent conditions that may justify out-of-area care include sprains, prolonged vomiting, severe cramps, minor burns, diarrhea, minor lacerations, and cold or sore throat with fever.
- Medically necessary services are not provided in the UPMC *for You* service area.

## Out-of-Network Care

UPMC *for You* members are not permitted to self-direct to out-of-network providers except for emergency services or for family planning services; however, providers can request out-of-network care.

A medical director will review the request and a representative will notify the provider of the determination by phone. If the request is denied, the provider also will receive written notification. The provider can appeal a denial by following the instructions outlined in the denial letter.

## Outpatient Surgery

Medically necessary outpatient surgeries listed on the Medical Assistance fee schedule are covered if performed by a network provider, hospital, or surgical facility. The provider must coordinate care with the member's PCP and call Medical Management at 1-800-425-7800 to authorize procedures listed on the Quick Reference Guide.

- ▶ See *Quick Reference Guide*, chapter E.

## Podiatric Care

Medically necessary podiatric care is covered with a referral from the member's PCP.

## Prescription Drug Coverage

The UPMC *for You* prescription plan features a closed, two-tier formulary and mandatory generic utilization, when available. For some medications, quantity limits, once-daily dosing, benefit exclusions, copayments and prior authorization programs may apply.

The plan offers limited over-the-counter products, when written on a prescription, including smoking cessation aids, and birth control. Members must use the UPMC *for You* pharmacy network. Copayments may apply.

▶ See *Pharmacy Services* chapter, *UPMC for You Pharmacy Program*, chapter J.



## Closer Look at Prescription Drug Coverage

Providers who have questions about prescriptions should call Pharmacy Services at 1-800-396-4139 from 8 a.m. to 5:00 p.m., Monday through Friday.

Effective January 1, 2009, UPMC *for You* members have the opportunity to receive a 90-day supply for the cost of 1 copayment through the 90-day retail pharmacy program.

▶ See *Pharmacy Services* chapter, *Where to Obtain Prescriptions*, chapter J.

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## Prosthetics and Orthotics

Prosthetic and orthotic services must be coordinated through a network provider.

Prosthetic and orthotic items on the Medical Assistance fee schedule are covered when medically necessary to treat congenital health defects or to improve function impaired by disease or accident.

Prosthetic and orthotic repairs and replacements are covered.

## Rehabilitative Therapy

### *Inpatient*

Inpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the member's PCP and delivered by a network provider. The therapy must be medically necessary and prior authorization must be obtained. The prognosis must indicate the potential for improvement.

Members age 21 and over who fall into the adult and general assistance benefit categories will be subject to an inpatient hospital rehabilitation benefit limitation of one visit per state fiscal year.

### *Outpatient*

Medically necessary outpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the member's PCP and delivered by a network provider. All outpatient rehabilitation visits require a referral from the PCP.

## Reproductive Procedures

### *Abortion*

An abortion may be covered when the mother's life is in danger or pregnancy is the result of rape or incest.

An abortion is covered when a physician certifies the abortion is necessary to prevent the death of the woman, which is a medical judgment to be made by the certifying physician.

A licensed physician may make the certification whether or not the physician has a pecuniary or proprietary interest in the abortion.

An abortion is covered for women who are victims of rape or of incest if:

- the rape victim makes a report to a law enforcement agency or public health service agency within 72 hours of the rape;
- the incest victim makes a report to a law enforcement agency or public health service agency within 72 hours of the time her physician informs her that she is pregnant.

The notification must occur before the abortion is performed.

The physician must complete a Physician Certification for an Abortion form (MA-3). This form must be maintained in the member's medical record.



### Closer Look at Cases of Rape and Incest

In cases of rape or incest, the member must sign a statement before the abortion (the statement does not have to be notarized). The provider should submit a copy of the statement along with the claim. The statement must note that the member:

- was a victim of rape or incest;
- reported the incident, including the identity of the offender, if known, to the appropriate law enforcement agency or county child protective service agency (in incest cases where the member is a minor); the statement must include the name of the agency as well as the date the report was made;
- is aware that any false statements and/or false reports to law enforcement authorities are punishable by law.

The reporting requirement may be waived if the member was the victim of rape or incest but, in the physician's medical judgment, was incapable of reporting the crime for physical or psychological reasons. The physician must give the reasons for the waiver on the Physician Certification for Abortion form and must obtain a signed, notarized statement from the woman indicating she was a victim of rape or incest and that she did not report the crime.

### *Hysterectomy*

A hysterectomy is covered when coordinated through a PCP or ob-gyn and performed by a network provider. The hysterectomy must be medically necessary and performed for a valid reason other than sterilization. A second opinion is not required, but the member may request one through her PCP or ob-gyn.

The provider and member must complete a Patient Acknowledgement for Hysterectomy form (MA-30). The consent form must be maintained in the member's medical record and a copy of the form must be submitted with the claim.

### *Tubal Ligation*

A tubal ligation is covered when coordinated through a PCP or ob-gyn and performed by a network provider.

The member must voluntarily give informed consent to the procedure. The member also must be at least 21 at the time she gives informed consent and must sign a Sterilization Consent form (MA-31) at least 30 days, but no more than 180 days, before the procedure in order to receive coverage. The consent form must be maintained in the member's medical record and a copy of the form must be submitted with the claim.

### *Vasectomy*

A vasectomy is covered when coordinated through a PCP and delivered by a network provider.

The member must voluntarily give informed consent to the procedure. The member also must be at least 21 at the time he gives informed consent and sign a Sterilization Consent form (MA-31) at least 30 days but no more than 180 days, before the procedure in order to receive coverage. The consent form must be maintained in the member's medical record and a copy of the form must be submitted with the claim.

## Skilled Nursing Facility Care

Skilled nursing facility care is covered if the treating provider obtains prior authorization and if the care is medically necessary.

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### Closer Look at Skilled Nursing Care

A member who enters a nursing facility will remain the responsibility of UPMC *for You* for up to 30 consecutive days. After 30 days, the member will be disenrolled from UPMC *for You* and returned to the Medical Assistance fee-for-service program. Continuity of care and transfer of medical records must be ensured during the transition.

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## Specialist Care

Coverage is provided for specialty care when performed by a network provider with a referral from the PCP. Coverage is only for those services coordinated by the PCP.

To ensure coverage, specialists must refer the member to network providers for laboratory testing and x-rays. Any additional services must be referred through the PCP.

Out-of-network services and/or any care ordered by an out-of-network provider are not covered unless specifically approved by Medical Management at 1-800-425-7800.

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## Therapy

Outpatient therapy (chemotherapy, dialysis, and radiation) is covered with a prescription when performed at a network facility.

## Urgent Care

Urgent care is defined as any illness, injury, or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become an emergency medical condition.

Urgent care is covered when the member is temporarily absent from the approved service area. Additionally, such services may be provided under unusual and extraordinary circumstances within the approved service area when a network provider is temporarily unavailable and when such services are medically necessary and require immediate attention.



### Closer Look at Urgent Care

If the member is unable to call the PCP before going to the emergency department and the member does not have an emergency medical condition, the emergency department should attempt to contact the PCP for approval and a referral before providing services. If the PCP does not respond within 30 minutes or cannot be reached, the emergency department or member should attempt to contact Provider Services at 1-800-286-4242. If the emergency department cannot reach UPMC *for You*, it should provide the service and attempt to contact the PCP or UPMC *for You* afterward.

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## Routine Vision Benefits

Routine Vision benefits are provided by OptiCare Managed Vision. Benefit coverage may vary.

Providers and Members may call OptiCare directly at 1-866-458-2138.

## Women's Health Routine

### Ob-Gyn Services

Members may self-direct care to a network ob-gyn for routine annual gynecological exams and obstetrical care.

### Non-routine Ob-Gyn Services

Members with women's health problems may self-direct care to a network ob-gyn.

## Family Planning

Members may self-direct care to any provider for family planning services.

## Pregnancy Care

Members can self-direct care to a network ob-gyn for maternity care and prenatal visits. The ob-gyn must notify the member's PCP in writing that the member is receiving maternity care.

UPMC *for You* enrolls pregnant members in the maternity program, which assesses pregnancy risks and offers members several prenatal services. The UPMC *for You* maternity program is called UPMC *for a New Beginning*. Members or providers may call the maternity program at 1-866-463-1462.

▶ See *Medical Management* chapter, *The Maternity Program*, chapter F.

Ob-gyns and PCPs are urged to complete a comprehensive assessment of their patients' physical, psychological, and emotional history. This information will be used to identify patients at risk for complications in pregnancy and who would benefit from enrollment in the maternity program.



### Closer Look at Obstetrical Needs Assessment Form

Providers should use the Obstetrical Needs Assessment forms, and fax to 412-454-8558. For questions about the form, or to obtain forms, providers may call the maternity program at **1-866-463-1462**.

▶ See *Medical Management* chapter, *The Maternity Program*, chapter F.

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## Expanded Benefits

Expanded benefits include the following:

- **Dental**—UPMC *for You* members may receive routine and emergency dental care. Benefits vary according to the member's Medical Assistance category.  
▶ See *Dental Benefits*, chapter E.
- **Health Management Programs**—UPMC *for You* offers several health management programs, including cardiovascular disease, diabetes, and asthma, at no cost to the member. Nurses are available to answer members' questions and offer support and advice between doctor visits. Call 1-866-778-6073 from 8:30 a.m. to 7 p.m. Monday through Friday.  
▶ See *Medical Management* chapter, *Health Management Programs*, chapter G.
- **Pharmacy**—Based on the member's Medical Assistance category, copayments may apply.  
▶ See *Pharmacy Services* chapter, *UPMC for You Pharmacy Program*, chapter J.
- **Pregnancy education**—A maternity program is available to all pregnant UPMC *for You* members. Outreach representatives and a registered nurse provide education by phone and coordination of care, with an emphasis on the psychosocial and socioeconomic issues that could affect a pregnancy. Information about the program is available at **1-866-463-1462**.  
▶ See *Medical Management* chapter, *The Maternity Program*, chapter G.
- **Vision**—UPMC *for You* members receive routine eye exams and coverage for lenses and frames or contact lenses. Benefits vary according to the member's Medical Assistance category.
- **MyHealth Advice Line** – A 24 hours a day/7 days a week advice line for members seeking general health advice or information regarding a specific medical issue, experienced registered nurses are available around the clock to provide members with prompt and efficient services.
- **Car Seat Program** - For enrollees engaged in prenatal care, incentive initiatives, such as a car seat incentive can be used to encourage members to participate in ongoing care and will address safe travel for baby. Criteria for such incentives can be the following:
  - Prenatal care prior to 13 weeks
  - Enrollment in Maternity Care Management Program
  - Compliance with lab testing as recommended by provider
  - Compliance with all prenatal care visits
  - Participation in all scheduled contacts by Maternity program staff
  - Return of signed consent form for the incentive
- **Member Advocate Program** - The Member Advocate program is free to all members. UPMC Health Plan members have access to a personal advocate that is their link to other UPMC Health Plan staff, such as health coaches and care managers. In addition, the

member's advocate is an advisor who can help them when they need to make important decisions about their medical, vision, dental, or pharmacy benefits.

▶ See *Vision Benefits*, chapter E.

## *Services Already Approved by Another Plan or Medical Assistance*

If a member, upon enrolling in UPMC *for You*, already is receiving services authorized by another PH-MCO or by the Medical Assistance fee-for-service program, those services will continue; however, the provider still must notify UPMC *for You* with information regarding those services.

Before authorization from the previous PH-MCO or fee-for-service program expires, consult the UPMC *for You* Quick Reference Guide for prior authorization and referral requirements.

▶ See *Quick Reference Guide*, chapter E .

## Services Not Covered

The following services are not covered under the UPMC *for You* program unless pre-approved by Medical Management at 1-800-425-7800:

- Acupuncture
- Emergency department services that do not meet the definition of “emergency services”
- Experimental or investigative treatments
- Home and vehicle modifications
- Infertility services
- Medical services or surgical procedures and diagnostic tests performed on an inpatient basis that could have been performed in the provider’s office, the clinic, the emergency department, or a short procedure unit without endangering the life or health of the member
- Non-medically necessary treatments or surgery (e.g., cosmetic surgery)
- Out-of-network care, except for emergency services and family planning
- Self-directed care, except as noted in the Coordinated Care section
  - ▶ See *Coordinated Care*, chapter E.
- Surgical and diagnostic procedures, and medical care and medications provided in connection with sex reassignment.



### Closer Look at Program Exception Process

The program exception process occurs when a provider requests Medical Management review of a service that is not a covered benefit to determine if an exception should be made based on medical necessity. The process also applies to benefit limitations, or when a provider requests additional treatment for a member who has exhausted the benefit limit (i.e., duration or quantity) of a particular service.

The Medical Management department will consider requests by providers for benefit exceptions for UPMC *for You* members.

To request a benefit exception for a UPMC *for You* member, the provider should submit a request to Medical Management and offer supporting information demonstrating the medical necessity of the exception.

For members under the age of 21, the medical director will review all requests to determine medical necessity. For members 21 and older, Medical Management will review all requests for program exceptions and determine whether the services are medically necessary. Urgent requests are reviewed and notification phoned to the provider within 24 hours. Non-urgent requests are reviewed and the provider is notified by telephone within 2 business days.

When a member initiates a request, a case manager will obtain the necessary medical information from the provider. The request will be reviewed for medical necessity by the medical director.

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## *The EPSDT Program*

### At a Glance

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides comprehensive preventive, acute, and chronic care services for children under 21 who are eligible for Medical Assistance.

The program attempts to discover and treat health problems before they become disabling and, therefore, more costly to treat. The program examines all aspects of a child's wellbeing and addresses any problems that are discovered.

UPMC *for You* acts as the primary carrier for EPSDT screens, obstetrical claims, and family planning services, regardless of other coverage. If, however, an EPSDT screen is received with another carrier's EOB, UPMC *for You* will coordinate benefits.

### Provider Responsibilities in the EPSDT Program

All UPMC *for You* providers must comply with the following responsibilities:

- Provide primary and preventive care to eligible UPMC *for You* members
- Act as a member advocate by providing, recommending, and arranging for medically necessary care
- Maintain the continuity of care for each member in his or her care
- Coordinate the member's physical and behavioral health care needs
- Provide referrals for any medical services that cannot be provided by the PCP, including referrals for network specialists and obtaining authorization for out-of-network care
- Locate, coordinate, and monitor all primary care and other medical and rehabilitative services for members
- Perform and report all EPSDT screens in the appropriate format, including all applicable procedure codes and modifiers
- Provide childhood lead poisoning prevention services in accordance with the DPW's EPSDT program requirements and lead screening guidelines established by the Centers for Disease Control (CDC).
- Coordinate and monitor the care provided to members by other health care practitioners
- Maintain a centralized and current medical record, including documentation of all services provided as well as referrals to specialists
- In cases of suspected developmental delay or elevated blood lead levels, the PCP must contact CONNECT at 1-800-692-7288 to refer the child for early intervention services
- Arrange all medically necessary follow-up care

- Arrange case management services for members with complex medical needs, including serious multiple disabilities or illnesses
- If necessary, provide the member's parent (or guardian) with information on how to access mental health services, or inform the appropriate county children and youth agency in cases of neglect or abuse
- Contact members who are not compliant with the EPSDT periodicity and immunization schedule, as indicated on the UPMC *for You* EPSDT roster. PCPs should contact members within 1 month of the non-compliance to schedule an appointment. PCPs also should document the reason for non-compliance and that efforts have been made to bring members into compliance.

▶ See *EPSDT Periodicity Schedule*, chapter E.

## EPSDT Appointment Scheduling and Outreach

UPMC *for You* conducts outreach to members eligible for EPSDT screenings. As part of this program, UPMC *for You* will:

- Contact new members to explain the EPSDT program
- Emphasize the importance of well-child preventive care and immunizations to all members
- Assist the member in scheduling an appointment with the PCP
  - Assist in scheduling a new member exam within 45 days of enrollment, according to the periodicity schedule, unless the child is already under the care of a PCP and is current with screens and immunizations
- ▶ See *EPSDT Periodicity Schedule*, chapter E.
- Assist in scheduling appointments for existing members who are due for a screening
- Monitor compliance to scheduled appointments when a child is age 2 and 13 through claims data

In situations where members continue to be non-compliant with making or keeping EPSDT screening appointments, UPMC *for You* also will attempt other outreach methods.



### Closer Look at EPSDT Roster

An EPSDT roster is sent every month to any provider who has a UPMC *for You* member under the age of 21. This roster contains information on members who are due for an EPSDT screening.

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## EPSDT Services

Under Pennsylvania and federal laws, the EPSDT program must provide the following services according to a periodicity schedule developed by the DPW as recommended by the

### American Academy of Pediatrics:

- Screening services, including a comprehensive health and developmental history, developmental assessment, nutritional assessment, and all appropriate immunizations
- An unclothed physical examination
- Health education and guidance
- Laboratory tests, including hemoglobin and hematocrit, urinalysis, iron levels, TB skin testing, sickle cell anemia screening, and lead levels (by the child's first birthday or as appropriate and consistent with the current CDC standard)
- Vision services, including diagnosis and treatment for defects in vision, and eye exams for the provision of glasses
- Hearing services, including diagnosis and treatment for defects in hearing, and testing or the provision of hearing aids
- Dental screening, including diagnosis and treatment of dental disease. PCPs should conduct an oral exam as part of the comprehensive examination.
- Dental screening (oral exam beginning at the eruption of the first tooth but no later than twelve months of age)
- Mental health services, including counseling
- Referral to behavioral health or medical providers to correct or ameliorate any problems discovered upon the screen, including those not covered on the Medical Assistance fee-for-service program
- Teenage pregnancy services or referral for those services
- All other medically necessary health care, diagnostic services, and treatment measures
- Autism Screening
- Developmental Screening

▶ See *EPSDT Periodicity Schedule*, chapter E.

Services are provided under the direction of the individual's PCP. When possible, it is preferable for the child to receive the examination and treatment from the same provider. If the PCP is unable to perform an examination or treatment, the provider must arrange for the services to be performed by another network provider. The PCP must coordinate and monitor the care provided by other practitioners and maintain a centralized medical record.

## Initial EPSDT Visits for Newborns

The first EPSDT visit should be the newborn physical exam in the hospital, providing that it includes all of the screening components. The claim should be submitted for reimbursement according to the provisions outlined in the provider contract.

## Diagnosis and Treatment in the EPSDT Program

If a screening examination or an encounter with a health professional results in the detection of a suspected problem, the child must be evaluated as necessary for further diagnosis. The diagnosis will help determine treatment needs. The EPSDT program covers the provision of all medically necessary health care services required to treat a condition diagnosed during an encounter with a

health care professional.

If a provider suspects developmental delay or detects elevated blood lead levels, the provider should refer the child for Early Intervention Services through CONNECT at 1-800-692-7288.

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### Closer Look at Providing Services to SSI or SSI-related Members

At the first appointment following enrollment of a Supplemental Security Income (SSI) member or SSI-related member (i.e. spouse and dependents), the PCP should conduct a complete assessment to determine the child's health care needs over an appropriate period (not to exceed 1 year). The initial appointment should occur within 45 days of enrollment with the Health Plan, unless the member already is receiving care with a PCP or specialist. The assessment should include the child's need for specialty care, which will be discussed with the caregiver, custodial agency and, when age-appropriate, the child. This assessment becomes part of the child's medical record.

The PCP, at the time of the initial exam, must make a recommendation regarding case management services. With the caregiver's or custodial agency's consent, the PCP should contact Special Needs at 1-800-286-4242 with a referral for case management services.

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## Childhood Lead Poisoning Prevention

Providers should administer childhood lead poisoning prevention services according to current guidelines from the Centers for Disease Control, which sets the standard for comprehensive childhood lead poisoning prevention services.

PCPs should conduct blood lead testing or refer the testing to a participating laboratory in accordance with the EPSDT periodicity schedule. Children with elevated lead levels are identified on the screening form by a diagnosis code.

▶ See *EPSDT Periodicity Schedule*, chapter E.

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### Alert—High Lead Levels

PCPs who discover patients under the age of 21 with blood lead levels higher than or equal to 10 must contact CONNECT at 1-800-692-7288 and also are requested to contact Special Needs at 1-800-286-4242 for monitoring.

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## EPSDT Expanded Services

Expanded services are those required to treat conditions a health care professional detects during an encounter with a member that may or may not normally be covered by the Medical Assistance program. UPMC *for You* members under the age of 21 are eligible for medically necessary expanded services.

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All requests for EPSDT expanded services should be forwarded to the Medical Management Department to request authorization. The request must include a letter of medical necessity describing the rationale for the request and the benefit the service will provide the member. Medical Management will review the request for medical necessity with the medical director. Urgent requests are processed within 24 hours to ensure that the child's medical care is not jeopardized.

The member and provider will be notified of the decision regarding the request for service within 21 days of the receipt of the request. This notice includes denials, reductions, or changes in scope or duration of services not responded to within 21 days. UPMC *for You* will approve and accept the financial responsibility for requests.

## EPSDT Data Collection and Follow-up

All PCPs must perform EPSDT screens according to the periodicity schedule.

▶ See *EPSDT Periodicity Schedule*, chapter E.

To receive reimbursement for an EPSDT screening, UPMC *for You* providers should submit their claims electronically or complete a CMS-1500 form utilizing the appropriate codes and modifiers, and send it within 90 days of the date of service to:

UPMC *for You*  
P.O. Box 2995  
Pittsburgh, PA 15230-2995

## School-Based and School-Linked Services

UPMC *for You* Special Needs Services coordinates school-based and school-linked services with providers to:

- Make sure PCPs interact with school-based centers as necessary
- Arrange for the coordination and integration of school-based health service information into the PCP's member record
- Help coordinate specialized treatment plans for children with special health care needs, including participation on interagency teams
- Provide outreach to members identified by school districts as not having received the full complement of EPSDT services, particularly treatment for dental, vision, or hearing problems that are identified in a school health screening

# Member Complaint and Grievance Procedures

## What Is a Complaint?

Members who are dissatisfied with the services they receive from UPMC *for You* or from their provider may file a complaint. Members also may file a complaint if UPMC *for You* did not pay for their care because they did not get a referral.

## What Should Members Do if They Have a Complaint?

Members should call Member Services at 1-800-286-4242 or write to:

UPMC *for You*  
Complaints and Grievances  
P.O. Box 2939  
Pittsburgh, PA 15219

TTY users should call 1-800-361-2629. Non-English speaking members should call Member Services at 1-800-286-4242 to be connected with our contracted language translation services representatives.

UPMC *for You* will investigate and review the complaint within 30 calendar days and send the member a letter within 5 business days explaining the decision.



### Alert

If a member files a complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service or item is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint. The complaint must be hand-delivered or postmarked within 10 calendar days from the date on the written notice of decision.

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## What if Members Are Unhappy with the Decision?

Members unhappy with the First-Level decision may make a Second-Level Complaint with

UPMC *for You*. That complaint must be received within 45 calendar days from the date the member receives written notice on the First-Level Complaint decision. Members have the right to meet with the Second-Level Committee and voice their opinions. The Second-Level Review is conducted within 30 calendar days from the receipt of the request for a Second-Level Complaint. Members will be notified by mail within 5 business days after the Second-Level Complaint Committee reaches a decision.

### What Can Members Do if They Do Not Like the Decision of the Second-Level Committee?

Members have 15 calendar days from receiving UPMC *for You*'s decision letter to file an External Review to either the Pennsylvania Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve policies and procedures.

Complaints must be sent in writing to either:

PA Department of Health  
Bureau of Managed Care  
Health & Welfare Building, Room 9  
12<sup>th</sup> and Forster Streets  
Harrisburg, PA 17120  
1-888-466-2787  
TTY: 1-800-654-5984

or

Pennsylvania Insurance Department  
Bureau of Consumer Services  
1209 Strawberry Square  
Harristown State Office Building #1  
Harrisburg, PA 17120  
1-877-881-6388

### What Is a Grievance?

A grievance is filed when members are unhappy about UPMC *for You*'s decision to:

- Deny a service
- Decrease a service
- Approve a service different from the service requested

## How Do Members Initiate a First-Level Grievance?

When UPMC *for You* issues a denial, decreases a service, or approves a service different from the service requested, members will receive a letter informing them about the grievance process. The grievance process has two steps: First-Level Grievance and Second-Level Grievance. Members have the right to participate in the First-Level Grievance review.

Members may send a grievance letter or call Member Services at 1-800-286-4242. TTY users should call 1-800-361-2629. Non-English speaking members should call Member Services at 1-800-286-4242 to be connected with our contracted language translation services representatives.

Providers may, at the member's written request, file a grievance on a member's behalf. The grievance should be sent to:

UPMC *for You*  
Complaints and Grievances  
P.O. Box 2939 Pittsburgh, PA  
15219

Grievances must be filed within 45 calendar days from the date of the notice regarding the denial, the decrease in services, or the approval of a different service.

If services that members currently are receiving are being denied, reduced or approved for a different service, members may wish to have services continue during the grievance process. To do this, members must file a grievance with UPMC *for You* within 10 calendar days from the date of the notice.

A UPMC *for You* staff member is available to assist the member in filing the grievance or during the grievance process at no cost to the member. This staff member will be someone who has never made a decision related to any part of the member's care.

UPMC *for You* will review the First-Level Grievance within 30 calendar days and send the member a letter with the decision within 5 business days. This letter will inform the member of the reason for the decision and how to file a Second-Level Grievance within 45 calendar days of receipt of the notice of the First-Level decision.

## Second-Level Grievance

UPMC *for You* will conduct a hearing within 30 calendar days of the receipt of the request for a Second-Level Grievance.

The member and the member's provider may participate in the Second-Level Grievance Committee meeting.

UPMC *for You* will inform the member of its decision by mail within 5 business days after the

Second-Level Grievance review is completed.

### External Grievance Procedure

After members exhaust the Internal Grievance Process, they may request an External Grievance Review through the Pennsylvania Department of Health by calling or sending a letter to the UPMC *for You* Complaints and Grievances Department.

Members must ask for an External Grievance Review within 15 calendar days of receiving a letter from UPMC *for You* about a Second-Level Grievance denial, approval of a different service or decision to decrease services.

UPMC *for You* will notify the member of the External Grievance reviewer entity's name, address, and phone number so that the member, if desired, can send the reviewer any additional information the member feels would help his or her case.

The External Grievance reviewer will notify the member in writing of the decision within 60 calendar days of filing the External Grievance.

### Expedited Complaints and Grievances

If a provider believes the usual timeframes for deciding a member's complaint or grievance will harm his or her health, the provider or the member can call Provider Services at 1-800-286-4242 and request that the complaint or grievance be expedited. Providers must send a fax to 412-454-7920 explaining why the member's health will be jeopardized by the typical timeframe.



For an expedited complaint or grievance, the provider must indicate in writing that a member's life or health is at risk. UPMC *for You* will send a letter within 48 hours informing the member of its decision.

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### DPW Fair Hearing Appeal

A member may ask for a DPW Fair Hearing Appeal. A member requests this appeal by sending a letter to DPW within 30 calendar days from the date of the notice by UPMC *for You* regarding the denial, decrease in services, or approval of a different service. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for a DPW Fair Hearing.

If services the member is currently receiving are being denied, reduced, or approved for a different service, the member may want to continue the services during the appeal. To do so, the member must file the appeal to DPW within 10 calendar days from the date of the notice from UPMC *for You*. The DPW Fair Hearing Appeal should be sent to:  
Pennsylvania Department of Public Welfare

Office of Medical Assistance Programs  
HealthChoices Program  
P.O. Box 2675  
Harrisburg, PA 17105-2675

## Expedited Fair Hearing

If a provider believes the usual timeframes for deciding a member's complaint or grievance will harm his or her health, the provider or the member can call the Department of Public Welfare at 1-800-798-2339 and ask for an expedited fair hearing. Providers will need to send a fax to 1-717-772-6328 explaining why the member's health could be jeopardized while waiting within the typical timeframe for a decision.

## *Quick Reference Guide*

The quick reference guides are available in the Reference Library on Provider OnLine at [www.upmchealthplan.com](http://www.upmchealthplan.com).

Hard copies are available upon request. Please contact Provider Services at the numbers listed below:

- *PMC for You* 1-800-286-4242

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## EPSDT Program Periodicity Schedule and Coding Matrix

### LEGEND

<sup>1</sup> Included in the assessment: a comprehensive history and physical examination; counseling/anticipatory guidance/risk factor reduction interventions; age-appropriate nutritional counseling; the calculation of Body Mass Index (BMI); newborn metabolic/hemoglobin screening and follow-up; growth measurements and head circumference; an oral dental exam; blood lead (BL) risk assessment; blood pressure risk assessment; developmental and autism screenings; developmental surveillance; psychosocial/behavioral assessments; alcohol and drug use assessment; and the ordering of appropriate laboratory/diagnostic procedures as recommended by the current AAP guidelines.

<sup>2</sup> Newborn metabolic and hemoglobinopathy screenings should be done according to state law. According to AAP recommendations, Newborn metabolic and hemoglobinopathy screenings should take place between newborn and 2 months of age.

<sup>3</sup> Use CPT modifier -52 EPSDT Screening Services/Components Not Completed *plus* CPT code for standard testing method for objective vision/hearing testing, anemia, dyslipidemia, lead and tuberculin testing not completed. If a screening service/component is reported with modifier 52, the provider must complete the screening service/component during the next screening opportunity according to the Periodicity Schedule.

<sup>4</sup> Use CPT modifier -90 Reference Outside Lab *plus* CPT code when laboratory procedures are performed by a party other than the treating or reporting physician.

<sup>5</sup> • indicates referral to a dental home, \* indicates administer oral health risk assessment. Assess need for fluoride supplementation. Determine whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one.

<sup>6</sup> Dental Periodicity Schedule: 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.

[www.aapd.org/media/Policies\\_Guidelines/G\\_Periodicity.pdf](http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf)

<sup>7</sup> Initial measurement of hemoglobin or hematocrit is recommended between 9 and 12 months of age.

<sup>8</sup> All sexually active patients should be screened for sexually transmitted infections (STI). All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).

<sup>9</sup> Procedure code 99431 and modifier EP are to be used for a newborn screen performed in the hospital, but not on the same day as hospital discharge.

<sup>10</sup> Procedure code 99435 and modifier EP are to be used for a newborn screen performed in the hospital on the same day as hospital discharge.

<sup>11</sup> Provide at times noted, unless done previously.

<sup>12</sup> Developmental Surveillance is required for all periods, except when developmental screenings are required.

<sup>13</sup> All referrals to a dental home must be reported using the YD referral code.

Add the "Recommendations for Preventive pediatric oral health care" - " periodicity recommendations" chart.

Add the Validated Screening tools for developmental delays and autism spectrum disorders chart.

## Validated Screening Tools for Developmental Delays and Autism Spectrum Disorders

The Pennsylvania Department of Public Welfare does not endorse or require any specific screening tool for screening purposes.  
This list is not all-inclusive, and other validated screening tools may be available.

### Developmental Delays

Validated Screening Tool	Age Range	Description	Administration Time	Where to purchase this tool and/or find additional information:
Ages & Stages Questionnaires (ASQ)  Available in English and Spanish	4 months to 5 years 6 months	A series of 21 questionnaires, depending on age of child, with a focus on: screening for communication; gross motor; fine motor; problem solving and personal adaptive skills. The parent completes one questionnaire. The provider scores by transferring answers to a scoring sheet, compares the child's scores to the cut-off points on the scoring sheet and communicates the results to the parent.	10-15 minutes	Ages & Stages website: <a href="http://www.agesandstages.com">www.agesandstages.com</a>  The Ages & Stages Questionnaires may be purchased from:  Paul H. Brookes Publishing Company (800) 638-3775 <a href="http://www.brookespublishing.com">www.brookespublishing.com</a>
			<b>Scoring Method</b> Risk categorization; provides a cutoff score in 5 domains of development that indicates possible need for further evaluation.	
Battelle Developmental Inventory Screening Test, 2nd ed (BDI-2)  Available in English and Spanish	Birth to 7 years 11 months	This directly administered screening tool is comprised of 96 items with a focus on: personal-social skills; adaptive behavior; psychomotor ability; communication and cognition (including subtests for fine and gross motor skills and expressive and receptive communications). The BDI-2 Screening Test can be modified for children with special needs.	10-30 minutes	The "BDI-2 Screener Test" and the "BDI-2 Screener Kit" may be purchased from:  Riverside Publishing Co. (800) 323-9540 <a href="http://www.riverpub.com">www.riverpub.com</a>
			<b>Scoring Method</b> Quantitative; scaled scores in all 5 domains are compared with cutoffs to determine need for referral.	
Bayley Scales of Infant and Toddler Development®, Third Edition Screening Test (Bayley-III®)  Available in English	1 month to 3 years 6 months	Development areas measured focus on: cognitive; language (expressive and receptive communications); fine motor and gross motor domains.	15-25 minutes	The Bayley-III® Screening Test may be purchased from:  Pearson (800) 211-8378 <a href="http://pearsonassess.com">http://pearsonassess.com</a>
			<b>Scoring Method</b> Cut scores according to age for cognitive, language and motor scales.	
Bayley Scales of Infant and Toddler Development®, Third Edition Motor Scale Kit (Bayley-III®)  Available in English	1 month to 3 years 6 months	Identifies motor delays in infants and toddlers. Includes growth charts for plotting motor growth over time, fine motor subtests and gross motor subtests.	10-20 minutes depending on the child's age	The Bayley-III® Motor Scale Test may be purchased from:  Pearson (800) 211-8378 <a href="http://pearsonassess.com">http://pearsonassess.com</a>
			<b>Scoring Method</b> Scaled scores, composite scores, growth scores. Includes percentile ranks and age equivalents.	

<p>Brigance® Infant &amp; Toddler Screen</p> <p>Available in English and Spanish</p>	<p>Birth to 23 months</p>	<p>Development areas measured focus on: fine and gross motor; receptive and expressive communications; self-help; and social-emotional scales. Accommodations are made for infants born prematurely (until age 2). The screen also has adjustments and separate cut-offs for children at psychosocial risks.</p>	<p>10–15 minutes</p> <p><b>Scoring Method</b></p> <p>Scoring software with technical report automatically computes chronological age and creates reports with at-risk cutoffs, growth indicators, percentiles, quotients, and age equivalents.</p>	<p>The Brigance® Infant &amp; Toddler Screen may be purchased from:</p> <p>Curriculum Associates Inc. (800) 225-0248 <a href="http://www.curriculumassociates.com">www.curriculumassociates.com</a></p>
<p>Brigance® Early Preschool Screen-II</p> <p>Available in English and Spanish</p>	<p>24 months to 5 years 11 months</p>	<p>Development areas measured focus on: fine and gross motor; general comprehension; speech and language; preacademic and academic, self-help and social-emotional scales.</p>	<p>10-15 minutes</p> <p><b>Scoring Method</b></p> <p>Scoring software with technical report automatically creates reports with at-risk cutoffs, growth indicators, percentiles, quotients, and age equivalents.</p>	<p>The Brigance® Early Preschool Screen-II may be purchased from:</p> <p>Curriculum Associates Inc. (800) 225-0248 <a href="http://www.curriculumassociates.com">www.curriculumassociates.com</a></p>
<p>Brigance® Inventory for Early Development-II (IED-II)</p> <p>Available in English and Spanish</p>	<p>Birth to 7 years</p>	<p>Development areas measured focus on: fine and gross motor; language; early academic and cognitive (quantitative/general and prereading/reading); daily living and social-emotional scales.</p>	<p>10-15 minutes</p> <p><b>Scoring Method</b></p> <p>Scoring software with technical report automatically creates reports with at-risk cutoffs, growth indicators, percentiles, quotients, and age equivalents.</p>	<p>The Brigance® Early Preschool Screen-II may be purchased from:</p> <p>Curriculum Associates Inc. (800) 225-0248 <a href="http://www.curriculumassociates.com">www.curriculumassociates.com</a></p>
<p>Child Development Review-Parent Questionnaire (CDR-PQ)</p> <p>Available in English and Spanish</p>	<p>18 months to 5 years</p>	<p>Development areas measured focus on: social; self-help; language; gross and fine motor skills. The provider may use this screen in two ways: as an observation guide and/or as a parent interview guide.</p>	<p>10–20 minutes</p> <p><b>Scoring Method</b></p> <p>Results are compared to age norms and classified as "typical" for age in all areas, or as "borderline" or "delayed" in one or more areas of development.</p>	<p>The CDR-PQ may be purchased from:</p> <p>Behavior Science Systems Inc. (612) 850-8700 <a href="http://www.childdevrev.com">www.childdevrev.com</a></p>
<p>Infant Development Inventory</p> <p>Available in English and Spanish</p>	<p>Birth to 18 months</p>	<p>A brief parent questionnaire used to track developmental skills with a focus on: social; self-help; language; gross and fine motor skills.</p>	<p>5–10 minutes</p> <p><b>Scoring Method</b></p> <p>Risk categorization; delayed or not delayed.</p>	<p>The Infant Development Inventory may be purchased from:</p> <p>Behavior Science Systems Inc. (612) 850-8700 <a href="http://www.childdevrev.com">www.childdevrev.com</a></p>

Parents' Evaluation of Developmental Status (PEDS)  Available in English, Spanish and Vietnamese	Birth to 8 years	Parents complete 10 questions designed for surveillance and/or screening of developmental and behavioral problems.	2–10 minutes	The PEDS may be purchased from:  Ellsworth & Vandermeer Press LLC (888) 729-1697 <a href="http://www.pedstest.com">www.pedstest.com</a>
			<b>Scoring Method</b>	
Parents' Evaluation of Developmental Status, Developmental Milestones (PEDS-DM®)  Available in English, Spanish and Vietnamese	Birth to 7 years 11 months	The PEDS-DM® can be used with the PEDS, or by itself. PEDS-DM® consists of 6-8 items per age/encounter and is designed to replace informal milestones checklists. Developmental areas measured focus on: expressive and receptive communications; fine and gross motor skills; self-help; social-emotional; and for older children, reading and math.	10-20 minutes	The PEDS-DM® may be purchased from:  Ellsworth & Vandermeer Press LLC (888) 729-1697 <a href="http://www.pedstest.com">www.pedstest.com</a>
			<b>Scoring Method</b>	
Capute Scales (also known as Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale [CAT/CLAMS])  Available in English, Spanish and Russian	3 months to 3 years	The Capute Scales is designed to help clinicians distinguish between global developmental delays and specific areas of concern. The Cognitive Adaptive Test (CAT) consists of 58 items focused on visual-motor functioning and the Clinical Linguistic and Auditory Milestone Scale (CLAMS) consists of 42 items focused on expressive and receptive language development.	6–20 minutes	The Capute Scales may be purchased from:  Paul H. Brookes Publishing Company (800) 638-3775 <a href="http://www.brookespublishing.com">www.brookespublishing.com</a>
			<b>Scoring Method</b>	
Communication and Symbolic Behavior Scales-Developmental Profile™ (CSBS-DP™): Infant Toddler Checklist  Available in English	6 months to 24 months	The CSBS-DP™ is designed to address language and cognitive skills. Development areas measured focus on: emotion and eye gaze; communication; gestures; sounds; words; understanding; and object use. Each area is measured by three main components: Infant Toddler Checklist; Caregiver Questionnaire; and the Behavior Sample.	5–15 minutes	The CSBS-DP™ Infant Toddler Checklist is copyrighted but remains free for use. Information may be found online at:  Paul H. Brookes Publishing Company (800) 638-3775 <a href="http://www.brookespublishing.com">www.brookespublishing.com</a>
			<b>Scoring Method</b>	
Early Language Milestone Scale (ELM Scale-2)  Available in English	Birth to 3 years	The ELM Scale-2 consists of 43 items designed to address speech and language development. Development areas focus on: Auditory expressive; auditory receptive; and visual.	1–10 minutes	The ELM Scale-2 may be purchased from:  Pro-Ed Inc. (800) 897-3202 <a href="http://www.proedinc.com">www.proedinc.com</a>
			<b>Scoring Method</b>	

## Autism Spectrum Disorders

Validated Screening Tool	Age Range	Description	Administration Time	Where to purchase this tool and/or find additional information:
Checklist for Autism in Toddlers (CHAT)  Available in English	18 months to 24 months	The CHAT consists of two sections designed to identify children at risk of Autism Spectrum Disorders. The two sections (9 parent-completed questions and 5 items of observation by a health care provider) focus on the developmental behaviors concerning joint attention and pretend play.	5 minutes	The CHAT remains free for use. Information and the screening tool may be found at:  The National Autistic Society +44 (0) 20-7833-2299 <a href="http://www.nas.org.uk/nas/jsp/polopoly.jsp?d=10">www.nas.org.uk/nas/jsp/polopoly.jsp?d=10</a>  Or by contacting:  Sally Wheelwright Autism Research Centre Cambridge University Douglas House 18b Trumpington Road Cambridge CB2 2AH, UK Tel: 01223 746057 Fax: 01223 746033
			<b>Scoring Method</b> Risk categorization (pass/fail)	
Modified Checklist for Autism in Toddlers (M-CHAT)  Available in English and Spanish	16 months to 4 years	The M-CHAT is an expanded American version of the original CHAT from the UK. The M-CHAT tests for Autism Spectrum Disorders against normally developing children and consists of 23 yes/no questions.	5–10 minutes	The M-CHAT is available for free download for clinical, research, and educational purposes. There are two authorized websites: the M-CHAT and supplemental materials can be downloaded from:  <a href="http://www.firstsigns.org">www.firstsigns.org</a> or from Dr. Robins' website, at <a href="http://www2.gsu.edu/~wwwpsy/faculty/robins.htm">http://www2.gsu.edu/~wwwpsy/faculty/robins.htm</a>
			<b>Scoring Method</b> Yes/no answers convert to pass/fail responses.	
Pervasive Developmental Disorders Screening Test-II (PDDST-II)  Available in English and Spanish	12 months to 4 years	The PDDST-II is a parent-completed questionnaire designed to screen for several autistic spectrum disorders, including autistic disorder, pervasive developmental delay, and Asperger's disorder.	10-20 minutes	The PDDST-II may be purchased from:  Pearson (800) 211-8378 <a href="http://pearsonassess.com">http://pearsonassess.com</a>
			<b>Scoring Method</b> Risk categorization (pass/fail)	
Social Communication Questionnaire (SCQ) (formerly Autism Screening Questionnaire-ASQ)  Available in English and Spanish	Anyone over 4 years of age, as long as his or her mental age exceeds 2.0 years	The SCQ is a parent-completed questionnaire consisting of 40 yes/no questions; designed to identify children at risk of autistic spectrum disorders. The SCQ is available in two forms: the <i>Lifetime Form</i> focuses on the child's entire developmental history; the <i>Current Form</i> looks at the child's behavior over the most recent 3-month period.	5–10 minutes	The SCQ may be purchased from:  Western Psychological Corp. (800) 648-8857 <a href="http://www.wpspublish.com">www.wpspublish.com</a>
			<b>Scoring Method</b> Risk categorization (pass/fail). Total score with cutoff points.	

The Pennsylvania Department of Public Welfare does not endorse or require any specific screening tool for screening purposes. This list is not all-inclusive, and other validated screening tools may be available.

**RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE**  
 Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs  
 (Adapted from the American Academy of Pediatric Dentistry)  
 EFFECTIVE MAY 1, 2009

<b>Periodicity Recommendations</b>					
<b>Age</b>	<b>Infancy 6-12 Months</b>	<b>Late infancy 12-24 Months</b>	<b>Preschool 2-6 Years</b>	<b>School Aged 6-12 Years</b>	<b>Adolescence 12-20 Years</b>
<b>Clinical Oral Examination: **</b> First examination at the eruption of the first tooth and no later than 12 months and every six months thereafter.	X	X	X	X	X
<b>Prophylaxis/ Topical Fluoride Treatment</b> Especially for children at high risk for caries and periodontal disease.	X	X	X	X	X
<b>Radiographic Assessment</b> As per Food and Drug Administration/American Dental Association Guidelines on Prescribing Dental Radiographs.	X	X	X	X	X
<b>Assessment for Pit and Fissure Sealants</b>			X First permanent molars as soon as possible after eruption	X Premolars, first and second permanent molars as soon as possible after eruption	X Second permanent molars and premolars as soon as possible after eruption
<b>Treatment of Dental Disease/ Caries Risk Assessment</b>	X	X	X	X	X

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**\*\*Anticipatory Guidance**

Appropriate discussion and counseling should be an integral part of each visit for care. Topics for counseling when appropriate should cover Oral Hygiene counseling (1), Injury, Prevention Counseling (2), Dietary counseling (3), Counseling for non-nutritive habits (4), Fluoride Supplementation (5,6), Assessment of oral growth and development (7), Counseling for speech/language development, Assessment and treatment of developing malocclusion, Counseling for intraoral/perioral piercing, Substance abuse counseling, Assessment and/or removal of third molars and Referral for regular periodic dental care/transition to adult dental care.

1. Initially, responsibility of parent; as child develops jointly with parents, and then by age 12 responsibility of the child only.
2. Initially play objects, pacifiers, car seats; then when learning to walk: sports, routine playing and intraoral/perioral piercing.
3. At every appointment discuss role of refined carbohydrates; frequency of snacking.
4. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. By clinical examination.