

UPMC *for You*

(Medical Assistance)



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At a Glance

UPMC *for You*, affiliate of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in 40 counties in the Commonwealth of Pennsylvania. This care is achieved by combining the benefits of a managed care organization with all the services covered by Medical Assistance. All UPMC *for You* 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 **1-866-918-1595** or visit www.upmchealthplan.com.

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 **1-866-918-1595** 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 a program called HealthChoices.

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 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 (BH-MCO) that contract with DPW.

UPMC *for You* is one of the PH-MCOs offered to recipients in the following zones:

- **Southwest Zone** - Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Green, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties
- **Lehigh Capital Zone** - Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties
- **New West Zone** – Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren counties

In these counties, Medical Assistance recipients enroll in a PH-MCO, or change plans, with the assistance of independent enrollment assistance representatives. Recipients may call the **Pennsylvania Enrollment Service Consumer Support Center** at **1-800-440-3989** or visit www.enrollnow.net. TTY users should call toll-free at **1-800-618-4225**.

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 **1-866-918-1595** 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 with a verbal referral and coordinated by a PCP (*Copayments and limits may apply to Chiropractor and Podiatrist visits*)
- 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 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 also indicates a need for 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.

To verify the coverage of any service, please contact **Provider Services** at **1-866-918-1595** or visit 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 *for You* imposes copayments for certain covered services and a member cannot afford to pay the 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 the 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
- provides an estimate of the cost to the member for the service.

The provider should document in the medical record that the member was advised of his or her financial responsibility 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.

For providers located in the **Southwest zone**, 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

Members should contact the **Medical Assistance Transportation Program (MATP)** county offices to arrange for most routine non-emergency ambulance transportation. MATP requires 24-hour notice and provides non-emergency medical transportation to and from MA-billable (compensable) non-emergency medical services, i.e., from home to the doctor's office for a routine visit.

- ▶ See *Medical Assistance Transportation Program (MATP) County Offices, Welcome and Key Contacts*, Chapter A.

Ancillary Services

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 have limits and/or copayments and require prior authorization review.

- ▶ See *Procedure Requiring Prior Authorization, Medical Management*, Chapter G.
- ▶ See *Quick Reference Guide, UPMC for You (Medical Assistance)*, Chapter E.

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 medically necessary manual spinal manipulations. Visit limits may apply for some members. For children under the age of 13, the member's PCP should coordinate chiropractic services. Children age 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.

Copayments and limits may apply for members age 21 and over. Copayments may apply for members ages 18 to 20.

- ▶ See *Quick Reference Guide, UPMC for You (Medical Assistance)*, Chapter E.
- ▶ See *Copayment and Limit Schedule, UPMC for You (Medical Assistance)*, Chapter E.

Dental Care

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

Avesis, Third Party Administrators, Inc., administers routine dental benefits for UPMC for You members. Members may self-direct their dental care to a network provider.

- Providers may call **Avesis** directly at **1-888-209-1243**.
- Members may call **Avesis** directly at **1-888-257-0474**.
- **TTY** user may call toll-free at **1-800-201-7165**.

Dental services for members age 21 and over

Members with **full dental benefits** who are 21 years of age and older and do not live in a nursing home or intermediate care facility (ICF) are eligible for the following services:

- One dental exam (oral evaluation) and cleaning (prophylaxis), every 180 days.
 - *Additional oral evaluations and prophylaxis will require a benefit limit exception (BLE).*
- One partial upper denture or one full upper denture; and one partial lower denture or one full lower denture.
 - *Once per lifetime*
 - *Additional dentures will require a BLE.*
 - *Note: If UPMC for You paid for a partial or full **upper denture** since March 1, 2004, the member can only receive another partial or full upper denture if they qualify for a BLE.*
 - *Note: If UPMC for You paid for a partial or full **lower denture** since March 1, 2004, the member can only receive another partial or full lower denture if they qualify for a BLE.*

The following services are not covered unless the member qualifies for a BLE:

- Crowns and adjunctive services
- Root canals and other endodontic services
- Periodontal services

Members with **limited dental benefits** who are 21 years of age and older and do not live in a nursing home or intermediate care facility (ICF) will be eligible for the following:

- Palliative care
- Conditions treated in short procedure unit (SPU), Ambulatory Surgical Center (ASC), or inpatient hospital

An exception to the dental service limits may be granted if the member meets certain criteria.

▶ See *Benefit Limit Exceptions, UPMC for You (Medical Assistance), Chapter E.*

Dental Limits for members over the age of 21:

- The following dental benefits and limits apply to members 21 years of age and older, including members 21 years of age and older who reside in personal care homes and assisted living facilities.
- The dental limits do not apply to members under 21 years of age or to adults who reside in a nursing facility or an intermediate care facility (ICF).
- Services beyond a member's benefit limits are not covered, unless the member or the provider requests and receives approval for a **Benefit Limit Exception (BLE)**.

Table E1: Dental Limits for Members Age 21 and Older

Description	Full Benefits		Limited Benefits
	Age 21 and older (<i>NOT Residing in a Nursing Facility or ICF</i>)	Age 21 and older (<i>Residing in a Nursing Facility or ICF</i>)	Age 21 and older
Anesthesia	Covered May require prior authorization	Covered May require prior authorization	Not Covered
Checkups – (Routine exam) -including x-rays	Covered - 1 per 180 days Additional exam requires a BLE	Covered	Not Covered
Cleanings - (Prophylaxis)	Covered - 1 per 180 days Additional cleanings requires a BLE	Covered	Not Covered
Crowns and adjunctive services	Not Covered Unless a BLE is approved	Covered Requires prior authorization	Not Covered
Dentures <i>-(One partial upper denture or one full upper denture and one partial lower denture or one full lower denture)</i>	Covered - Once per lifetime Requires prior authorization Additional dentures requires a BLE	Covered – 1 per 5 years Requires prior authorization	Not Covered
Dental surgical procedures	Covered Requires prior authorization	Covered Requires prior authorization	Not Covered
Dental emergencies - (Emergency care)	Covered	Covered	Not Covered
Extractions <i>-(Impacted tooth removal)</i>	Covered Requires prior authorization	Covered Requires prior authorization	Not Covered
Extractions <i>-(Simple tooth removals)</i>	Covered	Covered	Not Covered
Fillings - (Restorations)	Covered	Covered	Not Covered
Orthodontics (Braces)*	Not Covered*	Covered* Requires prior authorization	Not Covered
<i>*If braces were put on before the age of 21, services will be covered until they are completed or until age 23, whichever comes first, as long as the member remains eligible for Medical Assistance.</i>			
Palliative care - (Emergency treatment of dental pain)	Covered	Covered	Covered
Periodontal & endodontic services**	Not covered** Unless a BLE is approved	Covered** Requires prior authorization	Not Covered
**Exceptions to the periodontal limits will be granted for individuals who have special needs or are disabled, pregnant women, individuals with coronary artery disease, or individuals with diabetes.			
Root canals	Not covered Unless a BLE is approved	Covered Requires prior authorization	Not Covered
X-rays	Covered	Covered	Not Covered
Inpatient Hospital, Short Procedure Unit (SPU), or Ambulatory Surgical Center (ASC) dental care.	Covered*** Requires prior authorization	Covered*** Requires prior authorization	Covered*** Requires prior authorization
	***Oral surgery and impacted teeth removal if the nature of the procedure of the member's compromising condition would cause undue risk if performed on an outpatient basis. Or teeth extraction and dental restorative services for a member who is unmanageable and requires general anesthesia by an anesthesiologist, due to a severe mental and/or physical condition.		

Dental service for members under the age of 21

The following dental services are covered for members under the age of 21 when medically necessary:

- Anesthesia
- Cleanings
- Crowns – *requires prior authorization*
- Dental emergencies
- Dental exams - (Routine oral evaluations)
- Dental surgical procedures – *requires prior authorization*
- Dentures – *requires prior authorization*
- Extractions (simple tooth removals)
- Extractions (impacted tooth removals) – *requires prior authorization*
- Fillings
- Fluoride and varnish treatments
- Orthodontics (braces) - *requires prior authorization*
- Periodontal services – *requires prior authorization*
- Root canals – *requires prior authorization*
- Sealants
- X-rays



Closer Look at Braces

If braces were put on before the age of 21, services will be covered until they are completed or until age 23, whichever comes first, as long as the member remains eligible for Medical Assistance.

Members under the age of 21 are eligible to receive all medically necessary dental services. The member should be referred to a dental home as part of their EPSDT well-child screenings. A referral should be made beginning at age 3. Providers should notify the Special Needs Department of the referral utilizing the Dental Referral Fax form.

► See *The EPSDT Program, UPMC for You (Medical Assistance), Chapter E.*

The Department of Public Welfare's pediatric dental periodicity schedule provides recommendations for preventive dental care and screening recommendations for children, infancy through 20 years of age, for the following:

- Clinical oral evaluation
 - *Includes anticipatory guidance, i.e., information/counseling given to children and families to promote oral health*
- Prophylaxis/topical fluoride treatment
- Radiographic assessment
- Assessment for pit and fissure sealants
- Treatment of dental disease/caries risk assessment

▶ *See the Dental Periodicity Schedule, UPMC for You (Medical Assistance), 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, UPMC for You (Medical Assistance), Chapter E.*

Diagnostic Services

These services include laboratory services, x-rays, and special diagnostic tests. They are covered when ordered by a network provider and performed by a network ancillary provider. Copayments may apply for diagnostic services (medical or radiology diagnostic testing, nuclear medicine and radiation therapy).

▶ *See Copayment and Limit Schedule, UPMC for You (Medical Assistance), Chapter E.*

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, UPMC for You (Medical Assistance), Chapter E.*

Education

Members are eligible for the following health education classes:

- Breastfeeding
- Diabetes management
- Maternity
- Smoking cessation
- Nutritional counseling
- Childhood weight management



Closer Look at Education

Contact the **Special Needs Department** at **1-866-463-1462** for information on education classes.

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.

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 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.



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.

Family Planning

Members may self-direct care to network or out-of-network providers and clinics for family planning and birth control services. These services enable individuals to voluntarily determine family size and should be available without regard to marital status, age, sex or parenthood. UPMC *for You* members may access the education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures.



Closer Look at Family Planning

UPMC *for You* acts as the primary carrier for family planning services, regardless of other coverage. If, however, a claim is received with another carrier's Explanation of Benefits (EOB), UPMC *for You* will coordinate benefits.

Hearing Exams/Aids

Hearing exams require a PCP referral. Hearing aids are covered for UPMC *for You* members under the age of 21 when provided by a network provider.

Home Health Care

Home health care services are covered when coordinated through a network provider and include:

- Home health aides – *requires prior authorization*
- Home infusion therapy
- Medical social services
- Occupational therapy
- Physical therapy
- Private duty nursing in the home (for members under the age of 21) – *requires prior authorization*
- Registered dietitian services
- Skilled/intermittent nursing
- Speech therapy

The provider should call **Medical Management** at **1-800-425-7800** for a prior authorization review of medical necessity in order to receive coverage of private duty nursing services in the home (for members under the age of 21), or a home health aide.

Home Medical Equipment (HME)

Home medical equipment, i.e., hospital beds, manual wheelchairs, walkers, or respiratory equipment (including oxygen therapy) is covered when coordinated through a network provider and used for medically necessary services that are on the Medical Assistance fee schedule.

Specialized Home Medical Equipment (SHME)

Specialized home medical equipment, including but not limited to: Power Mobility devices, i.e., power wheelchairs and scooters; pressure reducing support surfaces; Lymphedema pumps, and bone growth stimulators require a prior authorization review, is covered when coordinated through a network provider and used for medically necessary services that are on the Medical Assistance fee schedule.

The provider must call **Medical Management** at **1-800-425-7800** for a prior authorization review of medical necessity in order to receive coverage of SHME.

▶ See *Quick Reference Guide, UPMC for You (Medical Assistance), 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 less. This care must be coordinated through a network provider.

Hospital Admissions

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.

Members who fall into the **general assistance benefit category** will have an inpatient hospital acute care benefit limitation of one visit per state fiscal year (July 1 through June 30).

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

▶ See *Copayment and Limit Schedule, UPMC for You (Medical Assistance), Chapter E.*

To review a member's individual schedule of benefits visit www.upmchealthplan.com, or call **Provider Services** at **1-866-918-1595**.

An exception to the inpatient hospital service limit may be granted if the member meets certain criteria.

▶ See *Benefit Limit Exceptions, UPMC for You (Medical Assistance), Chapter E.*

Immunizations

PCPs and specialists serving UPMC *for You* members who are 18 years of age or younger need to be enrolled in Vaccines for Children (VFC), a federally funded program that provides vaccines free of charge. To enroll in the **PA VFC Program** call **1-888-646-6864**.

PCPs may provide other immunizations not covered under VFC but covered by UPMC *for You*. To verify the coverage or to obtain additional information, call **Provider Services** at **1-866-918-1595**.

UPMC *for You* also covers certain adult immunizations. Call **Provider Services** at **1-866-918-1595** 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 *Special Needs Services, Medical Management, Chapter G.*

Mental Health and Substance Abuse Benefits

UPMC for You does not manage the member's behavioral health benefits. These services are managed by a behavioral health managed care organization (BH-MCO).



Closer Look at Behavioral Health Managed Care Organizations

- ▶ See *Table A3: UPMC for You (Medical Assistance Contacts), Welcome and Key Contacts, Chapter A.*

Office Visits

PCP visits are covered. Specialist visits are covered with a PCP referral and coordination. Copayments and limits may apply to Chiropractors and Podiatrist for some members.

- ▶ See *Copayment and Limits Schedule, UPMC for You (Medical Assistance), Chapter E.*



Closer Look at Referrals

UPMC for You **does not require the submission of paper referral forms**. PCPs may refer a member to a Network Specialist following standard medical referral practices such as calling the Specialist or by providing the member a "script" or letter for the Specialist's records. The PCP and Specialist should coordinate care.

The PCP and Specialist will need to contact **Medical Management** at **1-800-425-7800** for prior authorization approval of an out-of-network referral.

Organ Transplants

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 or Out-of-Network Care

Routine care performed by out-of-network providers is not covered for UPMC *for You* members.

Care for an emergency medical condition, provided by an out-of-network provider, is covered. Members are encouraged to notify their PCPs after they receive such care.

Medically necessary 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 and prior authorization is obtained.
- Delay would result in a significant decline in the member's health. Urgent conditions that may justify out-of-area care (by an out-of-network provider) include, but are not limited to, prolonged vomiting, severe cramps, burns, severe diarrhea, and minor lacerations.
- Medically necessary services are not available in the UPMC *for You* provider network and a prior authorization is obtained.

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. The provider should call **Medical Management at 1-800-425-7800** for a prior authorization.

A medical director will review the prior authorization request for medical necessity. The provider will be notified 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.



Alert—Services provided outside of the United States

Emergency and routine care provided outside the United States are not covered. The Affordable Care Act of 2010 prohibits payments to institutions or entities located outside of the United States. United States is defined to include the District of Columbia, Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

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 obtain authorization for procedures listed on the Quick Reference Guide.

- ▶ See *Quick Reference Guide, UPMC for You (Medical Assistance), Chapter E.*

Podiatric Care

Medically necessary podiatric care is covered with a referral from the member's PCP. Copayments and limits may apply for some members.

- ▶ See *Copayment and Limit Schedule, UPMC for You (Medical Assistance), Chapter E.*

Prescription Drug Coverage

The UPMC *for You* prescription plan features a closed, two-tier formulary and mandatory generic utilization, when available. A six-prescription per-month limit, 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. Based on the member's Medical Assistance category, copayments and limits may apply.

- ▶ See *UPMC for You Pharmacy Program, Pharmacy Services, 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 p.m., Monday through Friday.

UPMC *for You* members have the opportunity to receive a 90-day supply of some maintenance medication prescriptions for the cost of one (1) copayment through the "90-day retail pharmacy program."

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

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.

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

An exception to the inpatient rehabilitative therapy limit may be granted if the member meets certain criteria.

- ▶ See *Benefit Limit Exceptions*, UPMC for You (Medical Assistance), Chapter E.

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 and copayments may apply.

- ▶ See *Copayment and Limit Schedule*, UPMC for You (Medical Assistance), Chapter E.

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 that due to a condition, illness, or injury, an 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 and a copy submitted with the claim.



Closer Look at Cases of Rape and Incest

In cases of rape or incest, the member must complete and sign a **Recipient Statement Form (MA-368)** before the abortion (the statement does not have to be notarized). The provider must 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 is waived if the member was the victim of rape or incest but, in the physician's medical judgment was physically or psychologically incapable of reporting the crime. The physician must give the reasons for the waiver on the Physician Certification for Abortion Form and must obtain a signed statement from the woman indicating she was a victim of rape or incest and that she did not report the crime. A Recipient Statement Form is not needed for abortions necessitated by life-threatening conditions, illnesses, or injuries.

Hysterectomy

A hysterectomy is covered when coordinated through a PCP or ob-gyn provider 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 provider.

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 provider and performed by a network provider.

The member must voluntarily give informed consent to the procedure. The member also must be at least 21 years old 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 years old 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, the care is medically necessary and provided in a licensed facility.



Closer Look at Skilled Nursing Care

A member who enters a licensed skilled 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. Upon discharge from the nursing facility the member will be reenrolled in UPMC *for You*, (unless they are no longer eligible for medical assistance or they choose a new managed care organization).

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 and coordinated through the PCP.

Out-of-network services and/or any care ordered by an out-of-network provider are not covered unless specifically approved UPMC *for You*. The out-of-network provider must obtain prior authorization by contacting **Medical Management** at **1-800-425-7800**.

Therapy

Outpatient therapy (chemotherapy, dialysis, and radiation) is covered with a prescription when performed at a network facility. Copayments may apply for some members.

► See *Copayment and Limit Schedule, UPMC for You (Medical Assistance), Chapter E.*

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 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 **1-866-918-1595**. 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.

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**.

Members age 21 and older receive:

- Routine vision exams twice a year
- \$100 allowance toward eyeglasses (one frame and two lenses) or toward one pair of contact lenses and fitting per year. (If the member chooses standard eyeglasses or contact lenses that are within the allowance, there is no cost to the member. If the cost exceeds the allowance, the member will be responsible for any cost over the \$100.)
- Glasses or contact lenses to treat cataracts or aphakia (medical condition)
- Specialist eye exam with referral from PCP

Members under the age of 21 receive:

- Routine vision exams twice a year, or more often if medically necessary
- \$100 allowance towards eyeglasses (two frames and four lenses per year) or toward one pair of contact lenses and fitting. If the cost exceeds the allowance, the member will be responsible for any cost over the \$100. Exception to limits can be made if medically necessary and written documentation is provided.
- Replacement of eyeglasses or contact lenses if they are broken or lost or if there is a prescription change, provided written documentation of the necessity of the service is submitted by the provider.
- Eyeglasses and all other vision services deemed medically necessary provided written documentation of the necessity of the service is submitted by the provider.

Women's Health

Routine Ob-Gyn Services

Members may self-direct care to a network ob-gyn provider 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.



Closer Look at Women's Health Services

UPMC *for You* acts as the primary carrier for prenatal obstetrical claims (except hospital delivery claims) regardless of other coverage. If, however, a claim is received with another carrier's EOB, UPMC *for You* will coordinate benefits.

Family Planning

Members may self-direct care to any network or out-of-network provider and clinics for family planning and birth control services. These services enable individuals to voluntarily determine family size and should be available without regard to marital status, age, sex or parenthood.

- ▶ See *Covered Services - Family Planning, Medical Assistance, Chapter E.*

Pregnancy Care

Members can self-direct care to a network ob-gyn provider for maternity care and prenatal visits. The ob-gyn provider 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 *The Maternity Program, Medical Management, Chapter G.*

Obstetrical Needs Assessment Form (OBNA)

Ob-gyns and PCPs are urged to complete a comprehensive assessment of the member's physical, psychological, and emotional history. This information will be used to identify members 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 form, and fax it to 412-454-8558. For questions about the form, or to obtain forms, providers may call the **maternity program** at **1-866-463-1462**. Forms are also available on line at www.upmchealthplan.com/providers/medmgmt.html

▶ See *The Maternity Program*, Medical Management, Chapter G.

Other Services

Other services available to UPMC for You members include the following:

Health Management Programs — UPMC for You offers several health management programs, including asthma, cardiovascular disease (coronary artery disease and congestive heart failure), chronic obstructive pulmonary disease, diabetes, and maternity* at no cost to the member. Health coaches** are available to answer members' questions and offer support and advice between their visits. Information about the programs is available at **1-866-778-6073** from 8 a.m. to 5:30 p.m. Monday through Friday.

***UPMC for a New Beginning (UPMC for You's maternity program) —**

- **Maternity program and pregnancy education** — are available to all pregnant UPMC for You members. Health coaches provide education by phone and coordination of care, with an emphasis on the psychosocial and socioeconomic issues that could affect a pregnancy.
- **Baby Gift Incentive** — For enrollees engaged in prenatal care, incentive initiatives can be used to encourage members to participate in ongoing care and will address safe travel for the baby. Enrollees who meet the following criteria may be eligible to receive either an infant care seat or a portable play yard:
 - 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
 - Return a "Baby Gift Checklist" (form signed by provider verifying that the member attended all appointments and completed recommended lab testing)

Information about the program is available by calling the **Maternity Program** at **1-866-463-1462**.

- ▶ See *Health Management Programs, Medical Management, Chapter G*.
- ▶ See *The Maternity Program, Medical Management, Chapter G*.

***A health coach is a health care professional who specializes in the delivery of a wide spectrum of lifestyle programs for improving nutrition, increasing physical activity, quitting smoking or other tobacco use, managing weight, and more. They also deliver programs designed to help individuals better manage chronic health conditions such as diabetes, coronary artery disease, hypertension, asthma, and depression, to name a few.*

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. The MyHealth Advice line is available for medical questions concerning both adults and children. The member may call 1-866-918-1591. TTY users should call toll-free at 1-866-918-1593.

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.

▶ See *Vision Services, UPMC for You (Medical Assistance), Chapter E.*

Services Already Approved by Another MCO or Fee-for-Service

If a member, upon enrolling in UPMC *for You*, is receiving services authorized by another PH-MCO or by the Medical Assistance fee-for-service program, those services will continue for the length of time, quantity of services, and scope of services specified by the approved prior authorization. The length of time that the service will continue will vary if the member is over or under the age of 21 and/or the member is pregnant. However, the provider still must notify UPMC *for You* with information regarding those services. Contact **Medical Management** at **1-800-425-7800**.

Members under age 21:

The member will continue to receive any prior authorized service until the end of the time period previously authorized.

Members age 21 and over:

The member will continue to receive any prior authorized service up to sixty (60) days after enrollment with UPMC *for You*. Medical Management will conduct a concurrent clinical review of all pertinent information to determine if the services are medically necessary beyond the initial authorization period.

For members who are pregnant:

If a pregnant member is already receiving care from an out-of-network Ob-gyn provider at the time of enrollment, the member may continue (at her option) to receive an ongoing clinically appropriate course of treatment from that specialist throughout the pregnancy and postpartum care related to the delivery.

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, UPMC for You (Medical Assistance), Chapter E.*
- ▶ See *Services requiring Prior Authorization, Medical Management, Chapter G.*

Services Not Covered

The following services are not covered under the UPMC *for You* program unless pre-approved by **Medical Management**. Contact Medical Management by calling **1-800-425-7800** to determine if a service is eligible to be considered for a prior authorization:

- 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, UPMC for You (Medical Assistance), Chapter E.*
- Surgical and diagnostic procedures and medical care and medications provided in connection with sex reassignment

Program Exception Process

The program exception process occurs when a providers request 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 exception requests for 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 program exceptions and benefit limit exceptions for UPMC *for You* members.

Providers may submit exception requests for benefit limitations to **Medical Management** 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

The provider may request a benefit limit exception before or after the service has been delivered. A member may only request a benefit limit exception before the service is 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 and bill the member for services that exceed the limits unless the following conditions are met:

- The provider advised the member, before the service was provided, that the member has exceeded the limits.
- The provider advised the member, before the service was provided, that he or she will be responsible for payment if the exception is not granted.
- The provider has requested an exception to the limit and the request was denied.



Closer Look at the Exception Process

To request a program exception or a benefit limit 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.

When a member initiates a request, a Medical Management case manager will obtain the necessary medical information from the provider. The medical director will review all requests for program exceptions to determine medical necessity.

Urgent pre-service requests are reviewed for medical necessity and a determination will be made within 24 hours. Providers will receive oral notification of the decision within 24 hours receipt of the request in addition to a written notification. The written notification is sent to the provider within 24 hours and a copy is sent to the member. Prior to issuing a medical necessity denial letter, for members under the age of 21, the Medical director will make a reasonable effort to outreach to the ordering provider at least twice to attempt to obtain additional information to support medical necessity.

Non-urgent pre-service requests are reviewed for medical necessity and a determination will be made within two business days. Providers will receive oral notification of decision within two business days of receipt of the request. In addition, the provider will receive written notification within two business days of the oral notification. Prior to issuing a medical necessity denial notice for members under the age of 21, the medical director will make a reasonable effort to outreach to the ordering provider at least twice to attempt to obtain additional information to support medical necessity.

If the provider's request is for the continuation of services that the member is currently receiving and the medical director's medical necessity review results in termination or reduction of the service, the effective date of the termination of those services will be 10 days from the date of the denial letter. The services will continue at the previously approved level for an additional 10 days to allow the member the opportunity to appeal the decision. If the member requests an appeal within the required time frame, the previously approved level of service will continue until the appeal decision is rendered.



Closer Look at Inpatient, Inpatient Rehabilitation and Dental Benefit Limit Exceptions

Inpatient Benefit Limit Exception:

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.

Dental Benefit Limit Exception:

An exception to the dental benefit limits may be granted if:

- It is determined that the Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the member, or
- It is determined that the Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the member, or
- It is determined that granting a specific exception is a cost-effective alternative for UPMC *for You* or
- It is determined that granting an exception is necessary in order to comply with federal law.

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 well-being 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, a claim 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.
- Notify the Special Needs Department of dental referrals utilizing the appropriate fax form.
- 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 DPW's EPSDT program requirements and lead screening guidelines established by the Centers for Disease Control and Prevention (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. Include a copy of the completed validated developmental or autism screening tools used.
- 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. The referral must be documented in the medical record.
- 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 quarterly roster. PCPs should contact members within one 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. Members who are non-compliant may be referred to a **health coach** by contacting the **EPSDT Department** at **1-866-463-1462**.
 - ▶ See *EPSDT Periodicity Schedule*, UPMC *for You* (Medical Assistance), Chapter E.
 - ▶ See *Preventive Pediatric Oral Health Care Periodicity Recommendations*, UPMC *for You* (Medical Assistance), 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 appointments for existing members who are due for a screening.
- Assist in scheduling a new member exam within 45 days of enrollment with UPMC *for You*, 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, UPMC for You (Medical Assistance), Chapter E.*

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 quarterly to any provider who has a UPMC *for You* member under the age of 21. This roster contains information on members who are due and overdue for an EPSDT screening.

EPSDT Services

Under Pennsylvania and federal laws, the EPSDT program must provide the following services according to a periodicity schedule developed by 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)
- 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
- 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
- All other medically necessary health care, diagnostic services, and treatment measures
- Dental screening, including diagnosis and treatment of dental disease. PCPs should conduct an oral exam as part of the comprehensive examination.
 - ▶ See *Preventive Pediatric Oral Health Care Periodicity Recommendations*, UPMC for You (Medical Assistance), Chapter E.
- Autism screening, utilizing a standard screening tool
 - ▶ See *Validated Screening Tools Chart*, UPMC for You (Medical Assistance), Chapter E.
- Developmental screening, utilizing a standard screening tool
 - ▶ See *Validated Screening Tools Chart*, UPMC for You (Medical Assistance), Chapter E.
 - ▶ See *EPSDT Periodicity Schedule*, UPMC for You (Medical Assistance), 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**.



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 UPMC *for You*, 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 **1-866-463-1462** with a referral for case management services.

Childhood Lead Poisoning Prevention

Providers should administer childhood lead poisoning prevention services according to current guidelines from the Centers for Disease Control and Prevention, 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 should be identified on the CMS-1500 claim form utilizing the appropriate diagnosis code and EPSDT modifiers.

► See *EPSDT Periodicity Schedule*, UPMC *for You* (Medical Assistance), Chapter E.



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 the **Special Needs Department** at **1-866-463-1462** for monitoring. The referral to **CONNECT** must be documented in the medical records. Children with elevated lead levels should be managed according to CDC recommendations.

EPSDT Expanded Services

Expanded services are those required to treat conditions a provider 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.

All requests for EPSDT expanded services should be forwarded to the **Medical Management Department** at **1-800-425-7800** to obtain a prior authorization. The request must include a letter of medical necessity describing the rationale for the expanded services and the benefit the service will provide the member. Medical Management will review the prior authorization 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. If the decision to approve or deny a covered service or item is not made by the 21st day from the date the request was received, the service or item is automatically approved.

► *See [Services Requiring Prior Authorization](#), Medical Management, Chapter G.*

EPSDT Data Collection and Follow-up

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

- *See [EPSDT Periodicity Schedule](#), UPMC for You (Medical Assistance), Chapter E.*

To receive reimbursement for an EPSDT screening, 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

The UPMC *for You* Special Needs Department 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, as necessary
- Help coordinate specialized treatment plans for children with special health care needs, including participation on interagency teams

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 **UPMC for You Member Services** or write to the UPMC for You Complaints and Grievances Department:

**UPMC for You
Complaints and Grievances
P.O. Box 2939
Pittsburgh, PA 15230-2939**

- **Southwest zone** members should call **Member Services** at **1-800-286-4242**.
- **Lehigh Capital zone** members should call **Member Services** at **1-866-353-4345**.
- **New West zone** members should call **Member Services** at **1-855-425-8762**
- TTY users should call toll-free at **1-800-361-2629**.

Non-English speaking members should call **Member Services** to be connected with a contracted language translation service representative.

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 – To continue receiving services pending resolution

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.

What if members are unhappy with the decision?

Members who are 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 (DOH) or the Pennsylvania Insurance Department (PID). The DOH handles complaints that involve the way a provider gives care or services. The PID 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 912
7th and Forster Streets
Harrisburg, PA 17120
1-888-466-2787
TTY: 1-800-654-5984
Hours 8 a.m. to 4:30 p.m. Monday through Friday
or**

**Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harristown State Office Building #1
Harrisburg, PA 17120
1-877-881-6388
Hours - 8 a.m. to 5 p.m., Monday through Friday.**

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**.

- **Southwest zone** members should call **Member Services** at **1-800-286-4242**
- **Lehigh Capital zone** members should call **Member Services** at **1-866-353-4345**
- **New West zone** members should call **Member Services** at **1-855-425-8762**
- TTY users should call toll-free at **1-800-361-2629**

Non-English speaking members should call Member Services to be connected with a contracted language translation service representative.

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 15230-2939

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 time frames for deciding a member's complaint or grievance will harm his or her health, the provider can call **Provider Services** at **1-866-918-1595** 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 time frame.



Alert – Provider certification

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 of receiving the Provider certification or 3 business days of receiving the Member's request for an expedited review, whichever is sooner, informing the member of its decision.

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*. A DPW Fair Hearing Appeal should be sent to:

**Department of Public Welfare
OMAP - HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675**

The request for a Fair Hearing should include the following information:

- Member's name
- Member's Social Security number and date of birth
- Telephone number where the member can be reached during the day
- If the member wants a hearing in person or by telephone
- A copy of the decision letter

Expedited Fair Hearing

If a provider believes the usual time frames 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 time frame for a decision.

Quick Reference Guide

The quick reference guides are available in the Reference Library on Provider OnLine at www.upmchealthplan.com/providers/medmgmt.html.

Hard copies are available upon request. Please contact UPMC for You **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

Other Resources and Forms

<http://www.upmchealthplan.com/providers/epsdt.html>

- Childhood Nutrition and Weight Management Services
- Dental and Connect Referral form
- Dental Periodicity Schedule
- Developmental Delays or Autism Spectrum Disorders Screening Forms
- EPSDT billing guide
- EPSDT CMS-1500 claim form - Sample
- EPSDT Periodicity Coding Matrix
- EPSDT Periodicity Schedule
- EPSDT Periodicity schedule- day calculator
- EPSDT quarterly report - Sample
- Immunization schedule (0-6 years)
- Immunization schedule (7-18 years)

<http://www.upmchealthplan.com/providers/guidelines.html>

- Adult and Pediatric Preventive Guidelines
- CDC Adult Immunization Schedule
- Clinical Guidelines:
 - Cardiology
 - Diabetes
 - Respiratory
 - Women's Health

<http://www.upmchealthplan.com/providers/medmgmt.html>

- Obstetrical Needs Assessment form

Copayment and Limit schedule

Table E2: Copayments and Limit Schedule:

	Adult Medical Assistance Members Ages 18 and older	General Assistance Members Ages 18 and Older
Services	Copay	Copay
Ambulance (per trip)	\$0	\$0
Dental Care	\$0	\$0
Inpatient Hospital (Acute or Rehab)		
Per Day	\$3	\$6
Maximum with Limits	\$21	\$42
Medical Centers		
Emergency Department (non-emergent visits)	\$1 minimum - \$3 maximum	\$2 minimum - \$6 maximum
Ambulatory Surgical Center	\$3	\$6
Federal Qualified Health Center Regional Health Center	\$0	\$0
Convenience Care or Urgent Care Centers	\$2	\$4
Short procedure unit	\$3	\$6
Medical equipment		
Purchase	\$0	\$0
Rental	\$0	\$0
Medical Visits*		
Certified nurse practitioner	\$0	\$0
Chiropractor	\$2	\$4
Doctor , (PCP- OB/GYN)	\$0	\$0
Optometrist	\$0	\$0
Podiatrist	\$2	\$4
Therapy, (Occupational, Physical, Speech)	\$2	\$4
Outpatient Hospital		
Per Visit	\$2	\$4
Prescriptions**		
Generic	\$1	\$1
Brand	\$3	\$3
Diagnostic Services (not performed in a doctor's office)		
Medical diagnostic testing (per service)	\$1	\$2
Radiology diagnostic testing (per service)	\$1	\$2
Nuclear Medicine (per service)	\$1	\$2
Radiation Therapy (per service)	\$1	\$2
Limit – Notes*		
**Six prescription limit per calendar month for new prescriptions and refills	Applies to members age 21 and older	Applies to members age 21 and older
*18 visit limit per fiscal year, (July 1 st – June 30 th)	Applies to members age 21 and older	Applies to members age 21 and older
*Visits over 18 to PCPs are exempt from the limit.		
*Visits over 18 to Specialists are exempt, if coordinated & referred by the PCP, (except for podiatrists or chiropractors).		