

Medical Management



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At a Glance

The Medical Management Department at UPMC Health Plan is responsible for managing health care resources. To this end, the department:

- Authorizes coverage of certain procedures
- Performs predetermination reviews
- Authorizes out-of-network and out-of-area care
- Approves member transfers to out-of-network facilities
- Offers case management services for medically complex cases
- Provides access to special needs services
- Provides access to health management services for members with specific chronic diseases
- Administers member and provider surveys and assessments

For questions and additional information, call **Medical Management** at **1-800-425-7800** from 8 a.m. to 4:30 p.m., Monday through Friday.

Procedures Requiring Prior Authorization

Prior authorization, often referred to as pre-service decision, prospective review, precertification, or predetermination, is the process that UPMC Health Plan uses to review specific procedures or treatments to determine whether the coverage of a request will be approved or denied. UPMC Health Plan will review a provider's request to provide a service or course of treatment of a specific duration and scope to a member prior to the provider's initiation or continuation of the requested service.

A complete list of procedures that require prior authorization is available online at www.upmchealthplan.com.

- The Quick Reference Guides (QRG) list DME, services, and surgical procedures that require prior authorization.
- Medical policies outlining items, services, and procedures that require review for prior authorization

Hard copies are available upon request. Contact **Provider Services**.

► *See Provider Services, Welcome and Key Contacts, Chapter A.*

If a provider wishes to ask for a prior authorization review, a request can be submitted through the Provider Portal or a written request can be submitted to:

**UPMC Health Plan
Medical Management Department
U.S. Steel Tower, 11th Floor
600 Grant Street
Pittsburgh, PA 15219**

- ▶ See *How to Contact or Notify Medical Management*, Medical Management, Chapter G.

The provider must include the medical justification that will be considered in the approval or denial of the procedure. If coverage is denied, the provider may appeal the decision by following the appeal process that is included with the letter of denial.

- ▶ See *Medical Necessity Appeal*, Provider Standards and Procedures, Chapter B.



Closer Look—Treatment Elected by the Member

If approval is not granted, but the member elects to receive the treatment, the member must sign a statement accepting financial responsibility for the costs of the care prior to receiving the service. This statement must be retained in the medical record.

How to Contact or Notify Medical Management

Providers may contact the Medical Management Department when they have questions, need additional information, or want to request a review for prior authorization. They should call:

- **1-800-425-7800**, from 8 a.m. to 4:30 p.m., Monday through Friday

Providers may also request a prior authorization by:

- Submitting the requests, along with supporting clinical documentation, electronically through the online provider portal at www.upmchealthplan.com
- Faxing their request, which includes supporting clinical documentation and a letter or certificate of medical necessity (CMN) to:

- Clinical Operations Department at **412-454-2057**
 - For services and procedures requiring review for prior authorization
- Ancillary Services Department at **412-454-5255**
 - For DME, private duty nursing, and oral/enteral/parenteral formulas
- Sending a written request, including supporting clinical documentation and CMN, to:

**UPMC Health Plan
Medical Management Department
U.S. Steel Tower, 11th Floor
600 Grant Street
Pittsburgh, PA 15219**

When to Notify Medical Management

UPMC Health Plan (Commercial) Members

Providers must contact the Medical Management Department to authorize coverage for the following:

- Out-of-area and/or out-of-network care for a member, including the transfer of a member from one hospital to another
 - Coverage for certain specific procedures
 - Some home medical equipment (HME), including specialty wheelchairs and scooters, which are known as power mobility devices (PMDs)
 - Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, and long-term acute care centers. This enables UPMC Health Plan to identify members' special needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.
 - Any Prior Authorization service, item, or procedure listed on the Quick Reference Guide
- ▶ See *UPMC Health Plan Commercial Quick Reference Guide*, UPMC Health Plan (Commercial), Chapter C.

UPMC for You and UPMC Community HealthChoices (Medical Assistance) Members

Providers must contact the Medical Management Department to authorize coverage for the following:

- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, and long-term acute care centers. This enables UPMC for You and UPMC Community HealthChoices to identify members' special needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.

- Certain outpatient services, including pain management services, private duty nursing, enteral/parenteral feedings and nutritional supplements, and Early Periodic Screening, Diagnosis and Treatment (EPSDT) expanded services
- Skilled nursing facility care
- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs)
- Any Prior Authorization service, item, or procedure listed on the Quick Reference Guide
- Out-of-network services
- Benefit Limit Exception (BLE) requests

Note that this is not a complete listing of services that require a prior authorization.

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

Note that this is not a complete listing of services that require a prior authorization.

UPMC for Life (Medicare) Members

Providers must contact the Medical Management Department to authorize coverage for the following:

- Out-of-area and/or out-of-network care for a member, including the transfer of a member from one hospital to another
- Coverage for certain specific procedures
- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs)
- Acute inpatient admissions, skilled nursing facilities, rehabilitation, and long-term acute care. This notification is essential to ensure appropriate reimbursement and to meet UPMC Health Plan's reporting requirements to the Centers for Medicare & Medicaid Services.
- Any Prior Authorization service, item, or procedure listed on the Quick Reference Guide.

- ▶ See *UPMC for Life Quick Reference Guide, UPMC for Life (Medicare), Chapter F.*

UPMC for Kids (CHIP) Members Providers must contact the Medical Management department to authorize coverage for the following:

- Any Prior Authorization service, item, or procedure listed on the *UPMC for Kids Quick Reference Guide*
- Out-of-network services
- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs)

- Inpatient admissions to acute care hospitals, skilled nursing facilities, and rehabilitation facilities. This enables UPMC *for Kids* to identify members' special needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.
- Certain outpatient services, including private duty nursing, enteral/parenteral feedings, and nutritional supplements

▶ See UPMC *for Kids Quick Reference Guide, UPMC for Kids (CHIP), Chapter D.*

UPMC Medicare Special Needs Plans Members

Providers must contact the Medical Management Department to authorize coverage for the following:

- Out-of-area and/or out-of-network care for a member, including the transfer of a member from one hospital to another
- Coverage for certain specific procedures
- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs)
- Acute inpatient admissions, skilled nursing facilities, rehabilitation, and long-term acute care. This notification is essential to ensure appropriate reimbursement and to meet UPMC Health Plan's reporting requirements to the Centers for Medicare & Medicaid Services.
- Any Prior Authorization service, item, or procedure listed on the Quick Reference Guide

▶ See *UPMC Medicare Special Needs Plans Quick Reference Guide, UPMC Medicare Special Needs Plans (SNP), Chapter M.*



Closer Look at UPMC Medicare Special Needs Plans

UPMC *for Life Dual*

A Medicare Special Needs Plan that provides medical and prescription drug benefits for beneficiaries eligible for both Medicare Parts A and B, and full Medical Assistance. UPMC *for You Advantage* offers enhanced dental and vision benefits for dual eligible beneficiaries, along with extra benefits and services that help members manage their overall health and wellness. UPMC *for You Advantage* can also help coordinate a member's Medicare and Medicare Assistance services.

UPMC *for Life Options (HMO SNP)*

A Medicare Special Needs Plan that provides medical and prescription drug benefits for older beneficiaries who demonstrate long-term care needs. UPMC *for*

Life Options uses a small network of specialized providers and facilities to help members age in a setting that *they* choose, and offers extra services and benefits to give them and their loved ones the peace of mind they deserve.

All Members Providers are encouraged to call Medical Management to:

- Access special needs services
 - ▶ See *Special Needs Services, Medical Management, Chapter G.*
- Seek case management services for members with multiple or complex needs who require the skills and care of a variety of providers
 - ▶ See *Case Management Services, Medical Management, Chapter G.*
- Access special disease management or lifestyle programs and services
 - ▶ See *Health Management Programs, Medical Management, Chapter G.*



Alert—Emergency Care

Emergency services do not require prior authorization.

Providers should notify **Medical Management** at **1-800-425-7800** whenever they have directed a member to seek out-of-network emergency care.

Case Management Services

Case management is available to all UPMC Health Plan members who need assistance with coordinating health care services or accessing resources. Registered nurses and social workers, referred to as health coaches, assist members with needs spanning various aspects of social services and the medical community. There are two levels of case management services: complex and general.

- **Complex case management** is the coordination of care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources. Members who have a clinically advanced illness and multiple comorbid disease states and need help navigating the system to facilitate appropriate delivery of care and services are eligible for complex case management.
 - **General case management** applies to members involved in care management who need short-term support, basic education, or linked to resources.
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Closer Look at Diseases and Situations

Certain diseases and situations prompt a health coach to telephone a member seeking permission to be involved in the member's care. Situations that may prompt Case Management services may not be limited to those mentioned above. If a provider believes a member would benefit from case management, the provider should call **1-866-778-6073**.

Complex Case Management

At UPMC Health Plan, complex case management coordinates services for members with complex conditions and helps them access needed resources. Many times, complex case management members have a clinically advanced illness and multiple comorbid disease states and they need help navigating the medical care delivery system to receive appropriate care and services. At the same time members needing complex case management may have experienced a critical event or diagnosis that requires extensive use of resources and assistance for a short period.

Who is eligible?

Members with complex needs are identified through a variety of sources, including:

- Claims or encounter data related to use of services, types of providers seen, and cost of care
- Pharmacy data
- Hospital discharge data or information collected through Utilization Management processes, including precertification requests, concurrent reviews, prior authorization reviews, and reviews of hospital admission and readmission data

Members can also be referred to complex case management through:

- Practitioners
- The 24-hour nurse advice line (health information line)
- The staff managing the member as part of disease or health management programs
- A discharge planner
- Utilization Management staff
- Member, family, or another caregiver; self-referral
- Ancillary providers, behavioral health providers or behavioral health managed care organizations, pharmacists, the Medication Therapy Management Program, disability management programs, other internal departments, employer groups, or staff from community agencies

Enrollment in the Complex Case Management Program is voluntary and members may decide to disenroll at any time.

In addition to referrals from multiple internal and external sources, a monthly report is created based on claims data to identify those members who may benefit from the Complex Case

Management Program. These members may have experienced a critical event or received a diagnosis that requires the extensive use of resources. Most of the members who are identified need help navigating the health care system. These members can benefit from health coaches helping to educate them on their condition(s), addressing barriers, and linking them to needed services or community agencies.

What services are provided?

The program puts the member in touch with a health coach who will work with the member and his or her medical team. The health coach determines how to best assist the member after assessing the member's situation, intensity of needs for health care services, level of services needed, care coordination, education, and support. Coordination of the case management plan with the treating practitioner will occur where appropriate.

Specific assistance offered:

- An evaluation of the member's cultural and linguistic needs, preferences, or limitations
- An evaluation of the member's caregiver resources that are in place to support him or her with appropriate care and decision making
- An evaluation of available benefits and associated financial burdens, as well as what may be needed to support the member's treatment plan and identified needs
- Development of a case management plan that:
 - Addresses the identified needs;
 - Includes long- and short-term goals;
 - Establishes a time frame for re-evaluation;
 - Identifies resources to be used and at what level of care;
 - Provides continuity of care plan and determines the assistance that is needed; and uses a collaborative approach that identifies who will be included, such as family, practitioner, pharmacist, or community-based services.
- Identification of barriers to the member's meeting goals or complying with the plan, which includes such factors as poor compliance to treatment plan, lack of understanding, not ready to make a change, financial hardships, poor supports, transportation issues, or fragmented care
- Helping the member to develop a self-management plan which may include how he or she will monitor the disease, use a practitioner-provided symptom response plan, comply with prescribed medications, and attend practitioner visits
- Following the member's progress against the case management plan that was developed for the member, including progress toward overcoming identified barriers, any adjustments to the care plan, and following the self-management plan
- Coordination of care for multiple services, including inpatient, outpatient, and ancillary services
- Facilitating access to care
- Establishing a safe and adequate support system through interactions with the member and/or applicable caregivers

How can you refer a member for Complex Case Management Program?

Providers may refer a member for the Complex Case Management Program or ask questions about the program by calling **1-866-778-6073**. TTY users should call toll-free 1-800-361-2629. Representatives are available Monday through Friday from 7 a.m. to 8p.m., and Saturday from 8 a.m. to 3 p.m.

Special Needs Services

UPMC Health Plan offers Special Needs Services for UPMC *for You* (Medical Assistance) members who may have complex physical health needs, multiple physical or behavioral health needs, or special communication needs. Members may be handicapped or disabled and require community services, or they may just need extra guidance in obtaining health care services.

► See *Special Needs, UPMC for You (Medical Assistance)*, Chapter E.

Special Needs triggers include, but are not limited to, the following:

- Asthma
- Birth defect
- Cancer
- Developmental disability
- Diabetes
- Drug/alcohol problems
- Hearing impairment
- Heart disease
- High blood pressure
- HIV/AIDS
- Kidney problems
- Maternity
- Mental health conditions
- Mental retardation
- Physical disability
- Sickle cell disease
- Speech impairment
- Substitute care
- Transportation
- Visual impairment

- Wheelchair accessibility



Closer Look at Special Needs Services for UPMC *for You* Members

The Special Needs Department is staffed by nurses, social workers, and other professionals who are available Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. Any provider or member may contact **Special Needs** at **1-866-463-1462** for assistance in obtaining community services or other coordination of care services. TTY users should call toll-free at 1-800-361-2629.

Special Needs Services can:

- Coordinate health care services with providers and agencies
- Identify members who could benefit from case management and UPMC Health Plan health management programs
- Identify community agencies and services that may meet the needs of a member
- Function as the identified liaison with county children and youth agencies and juvenile probation offices
- Assist in coordinating routine transportation
- Educate members about how to access health care services within their benefit package
- Assist members who have reached benefit limits
- Assist members who are seeking treatment or services that are consistent with the members' cultural background
- Assist members who have difficulty communicating with making appointments
- Assist providers in locating language interpreters and those who can provide American Sign Language or other forms of visual/gestural communication
- Identify providers who speak foreign languages

UPMC Health Plan Care Management Department offers Special Needs Services for UPMC *for Best Health* (Healthy PA) members who may have complex physical health needs, multiple physical or behavioral health needs, or special communication needs. Members may be handicapped or disabled and require community services, or they may just need extra guidance in obtaining health care services. Care Managers will identify members who may benefit from care coordination. Care Management staff is available at 1-866-778-6073, Monday through Friday from 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m.

Health Management Programs

Health management programs are an important component of UPMC Health Plan's efforts to improve members' health by providing intensive case management for members with specific chronic illnesses.

UPMC Health Plan offers a maternity program and programs for members with diabetes; asthma; COPD; chronic heart disease, including heart failure, coronary artery disease, hypertension, and hyperlipidemia; depression; ADHD; and high risk behavioral health issues.

The goals are to improve clinical outcomes and quality of life. The program is structured to identify members with chronic conditions, conduct outreach, assess members' needs, develop a coordinated care plan that is created with members' input, and monitor members' progress with that plan. An assessment of members' medical and behavioral health, compliance status, use of self-monitoring tools, and their understanding of the condition is completed to determine areas for focused education or care coordination. All interventions are aimed at increasing members' knowledge of their condition and improving their ability to manage their disease. A specialized team of health coaches (nurse care managers and social workers), in collaboration with the members' providers, works to accomplish these goals through member education, coordination of care, and timely treatment.

In addition, these programs provide help for members to manage their chronic illnesses through preventive practices and adherence to their treatment plans. Health management programs also help form connections with community support groups and agencies.

UPMC Health Plan has programs to assist with lifestyle risk goals such as smoking cessation, weight management, nutrition, stress management, and physical exercise. Members enrolled in these programs receive educational materials and may be eligible for classes.



Alert—Weight Loss Drug Therapy

Drug therapy for weight loss is not a covered benefit.

Providers who serve members who would benefit from these health management programs should contact **Health Management** at **1-866-778-6073** for information and enrollment. Health Management staff is available Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. Additional information on health management programs can be found in the Provider section of the UPMC Health Plan website at www.upmchealthplan.com. If a member enrolls in a health management program, his or her provider will be notified.

Maternity Programs

UPMC Health Plan offers two maternity programs for pregnant members. Health coaches provide education by phone and coordination of care with an emphasis on achieving and maintaining a healthy pregnancy.

- **UPMC for a New Beginning** is a program that focuses on UPMC *for Kids* (CHIP), UPMC *for You*, and UPMC Community HealthChoices (Medical Assistance), and UPMC *for Life Advantage* (SNP) members.
- **UPMC Health Plan Maternity Program** is available for UPMC Health Plan (Commercial) and UPMC *for Best Health (Healthy PA)* members.



Closer Look at the Maternity Programs

For more information about the maternity programs call 1-866-778-6073. Health Management staff is available Monday through Friday from 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m., or you can send a fax to 412-454-8558.



Closer Look at Program Information

For more information about any of the Health Management programs, contact **Health Management** at **1-866-778-6073**.

Clinical and Preventive Health Care Guidelines

UPMC Health Plan strongly endorses the value of clinical practice guidelines. Guidelines that are relevant to members, critical to achieving positive health care outcomes, or useful in managing conditions where practice variation and differences in care can greatly affect the disease process are routinely evaluated.

The UPMC Health Plan Quality Improvement Committee (QIC) is responsible for guideline development and ongoing review. The QIC also assists UPMC Health Plan, which systematically monitors adherence to practice guidelines, in identifying opportunities for improvement when non-adherence is found.

▶ *See [Quality Improvement Program, Medical Management, Chapter G.](#)*

UPMC Health Plan reviews all practice guidelines annually and updates them as needed to reflect changes in recent scientific evidence or technology.

These guidelines may include:

- Adult cholesterol management
- Attention deficit/hyperactivity disorder
- Depression
- Diabetes mellitus health management guidelines for children and adults
- Evaluation and management of heart failure — outpatient
- Management of asthma in infants, children and adults
- Management of hypertension
- Prenatal care guidelines

UPMC Health Plan annually reviews and updates a schedule of pediatric (birth to age 19) and adult (19 years old and older) preventive health guidelines. UPMC Health Plan encourages its providers to follow these guidelines to reduce variation in care, prevent illness, and improve members' health.

UPMC Health Plan continues to add and revise guidelines. To see the most current clinical and preventive health care guidelines, go to www.upmchealthplan.com or call **Provider Services** for a hard copy.

▶ *See [Provider Services, Welcome and Key Contacts, Chapter A.](#)*

Member and Provider Surveys and Assessments

Health Assessment Survey

UPMC Health Plan performs a health assessment survey for some UPMC Community HealthChoices members, all new UPMC *for Kids* (CHIP) and UPMC *for Life* (Medicare) members and some UPMC Health Plan (commercial) members, based on employer group, to determine their clinical risk for the development of chronic illness. This tool assesses the member's clinical status and any psychological, emotional, or environmental issues that may affect his or her health. This information assists in identifying high-risk members for enrollment in case and health management programs. The survey results are sent to the appropriate provider to assist in the clinical management of these members.

Obstetrical Needs Assessment

Ob-gyns and PCPs performing routine gynecological services should complete an Obstetrical Needs Assessment Form (OBNAF), which is a comprehensive assessment of the physical, psychological, and emotional history of a UPMC Health Plan (Commercial), UPMC *for Best Health (Healthy PA)*, UPMC *for Kids* (CHIP), UPMC *for Life Advantage* (SNP), UPMC *for You* (Medical Assistance) and UPMC Community HealthChoices members. This information is used to identify members at risk for complications in pregnancy and who would benefit from enrollment in the maternity program. Providers must include their four-digit site ID number on the form. To obtain additional information about the provider's site ID number, call **Provider Services**.

▶ See *Provider Services, Welcome and Key Contacts*, Chapter A.



Closer Look at Obstetrical Needs Assessment Form

Providers are required to use the Obstetrical Needs Assessment Form and fax it to **412-454-8558**.

The OBNAF should be submitted within 30 days of the following visit dates:

- the initial visit between 28 and 32 weeks, and
- following the postpartum visit (21-56 days after delivery).

It is important that the dates of all the prenatal visits are included and risk factors are documented. This information is used to help identify members for the maternity program.

For questions about the form, or to obtain forms:

- call the **Maternity Program** at **1-866-778-6073**, or
- send a fax to 412-454-8558.

Blank forms, instructions, and an example of a completed form can be found on the UPMC Health Plan website at

www.upmchealthplan.com/providers/medical/resources/forms/medical-pa.aspx.

► See *Maternity Program*, Medical Management, Chapter G.

Member and Provider Satisfaction Surveys

UPMC Health Plan conducts annual surveys of both member and provider satisfaction. Participation by members and providers enables UPMC Health Plan to develop quality improvement plans.

The surveys assess:

- Access to care and/or services
- Overall satisfaction with the Health Plan
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Provider Performance Tracking

UPMC Health Plan is continuously analyzing and identifying best practices and areas of improvement regarding quality of care and cost-effectiveness. Only providers with a predetermined minimum number of UPMC Health Plan members are profiled.

These individual profiles compare providers to the performance of all other providers within their specialty and against national benchmarks. The profiles are distributed to providers semi-annually.

UPMC *for You* and UPMC Community HealthChoices (Medical Assistance) Provider Pay for Performance

UPMC *for You* and UPMC Community HealthChoices offers a Provider Pay for Performance (P4P) program in partnership with the Department of Human Services (DHS). The program is available to providers who participate with UPMC *for You* or UPMC Community HealthChoices and have a minimum number of members assigned to their practice. The P4P program offers providers the opportunity to receive incentive payments for the completion of visits, screenings, or other services related to specific HEDIS measures. The P4P program has both PCP and maternity related measures. For UPMC Community HealthChoices, Provider Pay for

Performance only applies to members whose primary insurance coverage is Medicaid.

Eligible providers participating in the program will receive quarterly rosters of members in each P4P measure, along with information on visits, screenings, or other services that have been completed or those that still need to be completed. Claims and quality improvement data are reviewed to determine completion rates and corresponding provider, 60 to 90 days of the completion of each quarter.

In addition, within 60 to 90 days of the completion of the calendar year, emergency room utilization by members at all P4P participating sites is reviewed and efficiency incentive payments are distributed based on sites with the lowest utilization in the 90th, 80th, and 70th percentiles for the year.

Ob-gyn and family practice providers (PCPs) who are credentialed to perform deliveries are eligible to participate in the maternity measures of the P4P program.

All aspects of the P4P program are reviewed by UPMC *for You* and UPMC Community HealthChoices on an annual basis and submitted to DHS annually for review and approval.

Quality Improvement Program

The goal of the Quality Improvement Program is to continually examine clinical and administrative operations to continuously improve UPMC Health Plan's ability to deliver high-quality, timely, safe, and cost-effective health care services.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID), and the Centers for Medicare & Medicaid Services (CMS).

The program critically assesses UPMC Health Plan's performance regarding customer service, provider satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

At the center of the program are the providers who serve on the Quality Improvement Committee (QIC). The QIC, representing both academic and community providers, operates directly under the auspices of the board of directors. The QIC is vital to UPMC Health Plan because it develops and evaluates clinical and operational standards for providers.

The Provider Agreement requires providers to comply with UPMC Health Plan's Quality Improvement Program. To obtain additional information, providers may go online at www.upmchealthplan.com or call **Provider Services**.

► *See Provider Services, Welcome and Key Contacts, Chapter A.*