UPMC Community HealthChoices
(Medical Assistance)

At a Glance

UPMC Community HealthChoices (UPMC CHC), of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in the Commonwealth of Pennsylvania. UPMC Community HealthChoices, as one of three state-wide Managed Care Organizations for the Commonwealth's Community HealthChoices (CHC) program, offers coverage for medical care and long-term services and supports to its participants. UPMC Community HealthChoices includes a vast network of medical and home and community-based providers.

UPMC Community HealthChoices is effective beginning January 1, 2018 in Pennsylvania's Southwest Zone; January 1, 2019 in Pennsylvania's Southeast Zone; and statewide January 1, 2020.

All UPMC CHC providers must abide by the applicable rules and regulations set forth under the General Provision of 55 Pa. Code, Chapter 1101.

Alert—Department of Human Services Regulations

This manual may not reflect the most recent changes to Department of Human Services regulations. Updates will be provided periodically. Call **Provider Services** at **1-844-860-9303** or visit **www.upmchealthplan.com**.

If providers have questions regarding UPMC CHC coverage, policies, or procedures that are not addressed in this manual, they may call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

Community HealthChoices Managed Care in Pennsylvania

Pennsylvania's Department of Human Services (DHS) contracts with three managed care organizations (MCOs) across Pennsylvania to offer managed care to recipients of Medical Assistance who are over the age of 21 and who require Long-Term Services and Supports (LTSS), and recipients who are over the age of 21 and eligible for both Medical Assistance and Medicare, under a program called Community HealthChoices.

Community HealthChoices

Recipients choose among managed care organizations contracted with DHS to provide at least the same level of service coverage offered by Pennsylvania's traditional fee-for-service (FFS) Medical Assistance program and § 1915(c) waiver programs. Behavioral health coverage is provided by behavioral health managed care organizations (BH-MCOs) that contract with state or county departments of human services.

UPMC CHC is one of three CHC-MCOs offered to recipients statewide in a staggered roll-out:

- **Southwest Zone (January 2018)** - Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties

- **Southeast Zone (January 2019) –** Bucks, Chester, Delaware, Montgomery and Philadelphia counties

- **Remainder of Pennsylvania (January 2020)** - Adams, Berks, Bradford, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Forest, Franklin, Fulton, Huntingdon, Jefferson, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Wayne, Wyoming, and York counties

Medical Assistance recipients who are over the age of 21 and receive LTSS and dual eligible Medicare/Medicaid recipients can enroll in a CHC-MCO, or change plans, with the assistance of an independent enrollment broker. Recipients may call the **Independent Enrollment Broker at 1-844-824-3655 or visit www.enrollchc.com. TTY users should call toll-free 1-833-254-0690.**

Population Served

Individuals participating in Community HealthChoices are at least 21 years old and:

- Receive Medicare and Medicaid (dual eligible), or
- Receive Medicaid AND long-term services and supports (LTSS) because their level of care makes them nursing facility eligible

Individuals are not eligible for CHC if they are:

- Receiving LTSS in the OBRA waiver and are not nursing facility clinically eligible; or
- An Act 150 program participant, who is not dually eligible for Medicare and Medicaid; or
- A person with an intellectual disability or autism who is receiving services beyond supports coordination through the Office of Developmental Programs; or
- A resident in a state-operated nursing facility, including the state veterans' homes.

Closer Look at the CHC population

- Participants may reside in a nursing facility or in the community
- Participants have the option of choosing UPMC CHC or one of two other CHC-MCOs for their Medicaid and LTSS coverage:
- Participants who are dual eligible may have different insurance plans for CHC and Medicare
- Participants may choose UPMC CHC as their Medicaid Plan *but choose an insurer for their* Medicare coverage that is not UPMC
- Participants may choose UPMC CHC as their Medicaid Plan *and choose UPMC for* their Medicare coverage (UPMC *for Life* Dual or UPMC *for Life* Medicare Advantage Plan
- Physical health providers do not need to be in UPMC CHC's network to provide services to dually eligible participants. Medicare providers can continue to see their patients and receive Medicare reimbursement.
- Participants with LTSS eligibility will have access to services and supports not generally provided by traditional Medicare or Medicaid physical health coverage.
  - See Covered Benefits for more detail.

Covered Benefit

At a Glance

UPMC CHC network providers supply a variety of medical benefits and LTSS services, some of which are itemized on the following pages. For specific information not covered in this manual, call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday. CHC includes but is not limited to all Medicaid FFS physical health services identified in the Medicaid State Plan and CHC 1915(c) Waiver services.

CHC Covered Physical Health Services	
Inpatient Hospital Services	**Clinic Services**
Inpatient Acute Hospital	Independent Clinic
Inpatient Rehab Hospital	Maternity – Physician, Certified Nurse Midwives, birth
Outpatient Hospital Clinic Services	Renal Dialysis Services
Outpatient Hospital Clinic	Ambulatory Surgical Center (ASC) Services
Outpatient Hospital Short Procedure Unit	**Dental Services**
Federally Qualified Health Center / Rural Health Clinic	**Physical Therapy, Occupational Therapy and Services for Individuals with Speech, Hearing, and Language Disorders**
Other Laboratory and X-ray Service	**Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in the treatment of diseases of the eye or by an optometrist**
Laboratory	Prescribed Drugs
Radiology (For example: X- rays, MRIs, CTs)	Dentures
Nursing Facility Services	Prosthetic Devices
Nursing Facility	Eye Glasses
Family Planning Clinic Services, and Supplies	**Diagnostic, Screening, Preventive, and Rehabilitative Services**
Physician Services	Tobacco Cessation
Primary Care Provider	Therapy (Physical, Occupational, Speech) - Rehabilitative
Physician Services and Medical and Surgical Services provided by a Dentist	**Certified Registered Nurse Practitioner Services**
Medical care and any other type of remedial care	**Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary**
Podiatrist Services	Ambulance Transportation
Optometrist Services	Non-Emergency Medical Transport
Chiropractor Services	Emergency Room

CHC Long-Term Services and Support (LTSS) Covered Services

In addition to physical health services, CHC offers Long-Term Services and Supports (LTSS) via Home and Community Based Services (HCBS) and long-term Nursing Facility care to participants evaluated to be Nursing Facility Clinically Eligible (NFCE). Some limitations may apply to certain services.

HCBS includes:

Service Coordination: Service Coordinators must assist Participants who need LTSS in obtaining the services that they need. Service Coordinators lead the PCSP process and oversee the implementation of PCSPs. Service Coordinators must identify, coordinate, and assist Participants in gaining access to needed LTSS services and other Covered Services, as well as non-covered medical, social, housing, educational, and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access to, locating, coordinating, and monitoring needed services and supports for Participants. Service Coordinators are also responsible for: informing Participants about available LTSS, required needs assessments, the PCSP process, service alternatives, service delivery options (including opportunities for Participant-Direction), roles, rights (including complaint, grievance, and DHS Fair Hearing rights), Participant's risks and responsibilities; assisting with fair hearing requests when needed and requested; and protecting a Participant's health, welfare, and safety an ongoing basis.

Personal Assistance Services (PAS): Personal Assistance Services primarily provide hands-on assistance to Participants that are necessary, as specified in the PCSP, to enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's PCSP. Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include care to assist with activities of daily living, health maintenance activities, routine support services and assistance and implementation of prescribed therapies.

Respite: Provided to support participants on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care.

Home Health Aide Services: Home Health Aide services are direct services prescribed by a physician to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. The physician's order must be obtained every sixty (60) days for continuation of service. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. Activities include personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist.

Nursing Services: Nursing services are direct services prescribed by a physician that are needed by the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant.

Physical Therapy: Physical Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant.

Occupational Therapy: Occupational Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant.

Speech and Language Therapy: Speech and Language Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Includes the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of, augmentative and alternative communication strategies

Therapeutic and Counseling Services: Services that assist individuals in improving functioning and independence and are necessary to improve the individual's inclusion in his or her community. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the Participant in the implementation of the plan. This service may be delivered in the Participant's home or in the community as described in the service plan. There are 4 types of therapeutic and counseling services:

- **Counseling Services:** Non-medical counseling services provided to participants in order to resolve individual or social conflicts and family issues.

- **Cognitive Rehabilitation Therapy:** Services focus on the attainment/re-attainment of cognitive skills. Intended to enhance the participant's functional competence in real-world situations. The process includes the use of compensatory strategies and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing.

- **Behavioral Therapy:** Services that assist individuals to improve functioning and independence and include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers.

- **Nutritional Counseling:** Assists the Participant and/or the Participant's paid and unpaid caregivers in developing a diet and planning meals that meet the Participant's nutritional needs, while avoiding any problem foods that have been identified by a physician.

Community Integration: Short-term, goal-based support service designed to assist participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community.

Benefits Counseling: Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking competitive integrated employment or career advancement. Benefits Counseling is a service designed to inform, and answer questions from, a Participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc. The service also will provide information and education to the Participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Employment Skills Development: Employment Skills Development services provide learning and work experiences, including volunteer work, where the participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Be individually tailored to directly address the participant's employment goals as identified in the needs assessment and included in the service plan.

Job Finding: Job Finding is an individualized service that assists Participants in obtaining competitive, integrated employment paid at or above the minimum wage. Job Finding identifies and/or develops potential jobs and assists the Participant in securing a job that fits the Participant's skills and preferences and employer's needs.

Career Assessment: Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the Participant. Services support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. This service includes Discovery for individuals who, due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments which compare the individual to others or arbitrary standards of performance and/or behavior. The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

Job Coaching: Individualized services providing ongoing support to learn a new job and maintain a job in a competitive employment arrangement in an integrated work setting in a position that meets job and career goals; also utilized for participants who are self-employed.

Personal Emergency Response System (PERS): An electronic device which enables participants to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

Home Adaptations: Physical adaptations to participant's private residence to ensure the health, welfare and safety of the participant, and enable the participant to function with greater independence. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home.

Pest Eradication: Pest eradication services will be available to make a Participant's home fit for the Participant to live there. Pest Eradication Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant's residence.

Home Delivered Meals: The Home Delivered Meals service provides meals that meet at least one-third (1/3) of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves or for whom the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation.

Assistive Technology: Assistive Technology service is an item, piece of equipment or product system—whether acquired commercially, modified or customized—that is needed by the Participant. The service is intended to ensure the health, welfare and safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities.

Specialized Medical Equipment and Supplies: Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the Participant and are directly related to a Participant's disability. These services or items are necessary to ensure health, welfare and safety of the Participant and enable the Participant to function in the home, community, or nursing facility with greater independence. This service is intended to enable Participants to increase, maintain, or improve their ability to perform activities of daily living.

TeleCare Services: TeleCare integrates social and health care services supported by innovative technologies to sustain and promote independence and quality of life and to reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary, to enable the Participant to promote independence and to ensure the health, welfare and safety of the Participant and are provided pursuant to consumer choice. TeleCare includes: 1) Health Status Measuring and Monitoring TeleCare Service, 2) Activity and Sensor Monitoring TeleCare Service, and 3) Medication Dispensing and Monitoring TeleCare Services.

Non-Medical Transportation: Non-medical transportation includes transportation to community activities, grocery shopping, religious services, Adult Daily Living centers, employment and volunteering, and other activities or LTSS services as specified in the Participant's PCSP.

Vehicle Modifications: Vehicle modifications are modifications or alterations to an automobile or van that is the participant's means of transportation to accommodate the special needs of the participant. Vehicle modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community.

Adult Daily Living: Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant.

Adult Daily Living includes two (2) components: Basic Adult Daily Living services and Enhanced Adult Daily Living services. Basic Adult Daily Living Services include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

Structured Day Habilitation: Structured Day Habilitation Services help with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver Participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice, as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Services include social skills training, sensory/motor development, and education/elimination of maladaptive behavior. Services are directed at preparing the Participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, and money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living, including whatever assistance is necessary for maintaining personal hygiene. Services must be separate from the Participant's private residence or other residential living arrangement. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. The direct services must be personal care or directed toward the acquisition of skills.

Residential Habilitation: Residential Habilitation services are provided for up to 24 hours per day. Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (e.g., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (e.g., cooking, housework, and shopping). Transportation is provided as a component of the Residential Habilitation service.

Community Transition Services: Community Transition Services are one-time expenses for Participants that make the transition from an institution to their own home, apartment or family/friend living arrangement. Community Transition Services may be used to pay the necessary expenses for a Participant to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

- Equipment, essential furnishings and initial supplies (e.g., household products, dishes, chairs, tables).
- Moving Expenses.
- Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement.
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)
- Items for personal and environmental health and welfare (e.g., personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy).

Transition Service Coordination: Services which prepare and support the participant's move from a nursing facility to housing in an integrated setting. These services include assistance to obtain and retain housing, activities to foster independence, oversight of community transition services and assistance in developing community resources to support and maintain residency in the community

Participant Directed Goods and Services: Participant-Directed Goods and Services are services, equipment or supplies limited to Participants that are utilizing Budget Authority for Participant-directed service.

Participant Directed Community Supports: Participant-Directed Community Supports will be offered to Participants utilizing budget authority. Participant-Directed Community Supports are specified by the PCSP, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. The Participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the Participant. Services include assisting the Participant with the following:

- Basic living skills, such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living.
- Health maintenance activities, such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities.
- Improving and maintaining mobility and physical functioning.
- Maintaining health and personal safety.
- Carrying out household chores, such as shopping, laundry, cleaning and seasonal chores.
- Preparation of meals and snacks.
- Accessing and using transportation (If providing transportation, the support services worker must have a valid driver's license and liability coverage as verified by the F/EA).
- Participating in community experiences and activities.

Financial Management Services (FMS): fiscal-related services to Participants choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for Participants while making sure funds used to pay for services and supports as outlined in the Participant's PCSP are managed and disbursed appropriately as authorized.

CHC LTSS services provided in a nursing facility include:

Nursing Facility Services: Professionally supervised nursing care and related medical and other health services furnished by a health care facility licensed by the Pennsylvania Department of Health. Participants must be NFCE to receive nursing facility services under the CHC Program.

Exceptional Durable Medical Equipment: Specially adapted medical equipment that is uniquely constructed in accordance with the written orders of a physician for the use of one resident, making its contemporaneous use by another resident unsuitable.

To learn more about LTSS covered services, contact **Provider Services** at **1-844-860-9303.**

Key Points

UPMC CHC covers:

- PCP visits.
- Specialist visits with a verbal referral and coordinated by a PCP
- Emergency services.
- Prenatal care.
- Long-term services and supports (LTSS) for eligible CHC participants
- Participants eligible for LTSS have a service coordinator to coordinate services

Coordinated Care

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

When needed, participants can seek a second opinion from a qualified provider within the Network, at no cost to the participant. If a qualified Provider is not available within the Network, participant will receive assistance in obtaining a second opinion from a qualified provider outside the Network, at no cost to the participant, unless co-payments apply.

In providing and coordinating care, providers must distinguish between traditional treatments and non-traditional methods consistent with participants' racial, ethnic, linguistic or cultural backgrounds.

Upon notification by the participant, family member, participant's legal designee, or a hospital emergency department, the participant's PCP must coordinate any care related to an emergency. Participants may self-direct their care for routine gynecological examinations, family planning, maternity care or prenatal visits, dental care, vision care and Indian Healthcare Providers

To verify the coverage of any service contact **Provider Services** at **1-844-860-9303** or visit or **www.upmchealthplan.com**

All payments made to providers by UPMC CHC constitute full reimbursement to the provider for covered services rendered. Please refer to the provider contract for specific fee schedules. If UPMC CHC imposes copayments for certain covered services and a participant cannot afford to pay the copayment, providers must render covered services to the participant despite non-payment of the copayment by the participant. This shall not preclude providers from seeking payment for the copayments from participants after rendering covered services.

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

- of the nature of the service;
- that the service is not covered by UPMC CHC and UPMC CHC will not pay for the service; and
- of an estimate of the cost to the participant for the service.

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

Standards for Participant Access to Services (Wait Time for Appointments)

The Department of Human Services (DHS) standards require that participants be given access to covered services in a timely manner, depending on the urgency of the need for services, as follows:

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

- See additional Appointment Standards in charts below

New Participants

First examination	For your first examination, you must be seen by:
Participant with HIV/AIDS	PCP or specialist no later than seven days after you have become a participant of UPMC CHC unless you are already being treated by a PCP or specialist.
Participant who received Supplemental Security Income (SSI)	PCP or specialist no later than 45 days after you have become a participant of UPMC CHC unless you are already being treated by a PCP or specialist.
All other Participants	PCP visit no later than three weeks after you have become a participant of UPMC CHC.

OB/GYNs and PCPs

Emergency	Must be seen immediately or referred to an emergency room.
Urgent medical conditions	Must be scheduled within 24 hours of request.
Routine care	Must be scheduled within 10 business days of request.
Wellness (physical, wellness exam, well-child exam)	Must be scheduled within 3 weeks of request.
Well-woman exams	Must be scheduled within 3 weeks of request.

OB/GYNs and PCPs… (con't)

Maternity care	Initial prenatal care appointments must be scheduled: • First trimester – within 10 business days of request. • Second trimester – within 5 business days of request. • Third trimester – within 4 business days of request. • High-risk pregnancies – within 24 hours of notifying the provider of the high risk, or immediately, if an emergency exists.
Non-Urgent Sick Visits	Within 72 hours of request
If participant reports to ER but does not require or receive care for symptoms	Promptly

Your PCP and ob-gyn must be available to you 24 hours a day, 7 days a week, every day of the year. They may have an answering service or paging system that will contact them after their office has closed. Leave a phone number where the PCP or ob-gyn can call you back.

Specialists

Emergency cases	Must be seen immediately or referred to an emergency room.
Urgent medical conditions	Must be scheduled within 24 hours of request.
Routine care	Must be scheduled within 15 business days of request for the following specialty providers: Otolaryngology Orthopedic Surgery Dermatology Dentist Pediatric Neurology Pediatric Nephrology Pediatric Allergy & Immunology Pediatric Pulmonology Pediatric Endocrinology Pediatric Rehab Medicine Pediatric Gastroenterology Pediatric Rheumatology Pediatric General Surgery Pediatric Urology Pediatric Hematology Pediatric Oncology Pediatric Infectious Disease Must be scheduled within **10 business days of request for all other** specialty providers

Ambulance

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

All requests for medically necessary Medicaid covered non-emergency transportation must be coordinated through **UPMC Medical Transportation** at **1-877-521-RIDE (7433) or PARC at (412) 647-7180** for the following:

- Air ambulance
- Ground ambulance
- Wheelchair van transportation

Closer Look at Routine Medical Transportation

Participants should contact the **Medical Assistance Transportation Program (MATP)** county offices to arrange for most routine non-emergency transportation. MATP requires 24- to 72-hour notice and provides non-emergency transportation to and from MA-billable (compensable) non- emergency medical services, e.g., from home to the doctor's office for a routine visit.

If the participant has an unusual non-emergency transportation need due to a medical condition, UPMC CHC Health Care Concierge Team can be contacted for assistance. **UPMC CHC Health Care Concierge Team** can be reached 24 hours a day by calling **1-844-833-0523**

UPMC CHC participants with LTSS have service coordinators who can assist participants to sign up and schedule rides with MATP. For more information contact **Provider Services** at **1-844-860-9303.**

➢ 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 require prior authorization review. Certain CHC participants are eligible for long-term services and supports and may receive home and community-based services coordinated by a Service Coordinator.

- See Procedures Requiring Prior Authorization, Medical Management, Chapter G.
- See Covered Benefits, UPMC CHC (Medical Assistance), Chapter N

Chiropractic Care

UPMC CHC participants may self-direct to chiropractic care. Chiropractic services are covered when delivered by a network provider. UPMC CHC covers only one evaluation per year and medically necessary manual spinal manipulations.

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

Dental Care

Avesis, **Third Party Administrators Inc.,** administers routine dental benefits for UPMC CHC participants. Participants may self-direct their dental care to a network provider.

- Providers may call **Avesis** directly at **1-888-209-1243.**
- Participants may call **Avesis** directly at **1- 833-241-4245.**
- **TTY** users may call toll-free **711.**

Dental Services

UPMC CHC participants who 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.
  - *Service is covered once per lifetime.*
  - *Additional dentures will require a BLE.*
  - **Note:** If UPMC *for You* paid for a partial or full **upper denture** since April 27, 2015, the participant 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 April 27, 2015, the participant can only receive another partial or full lower denture if they qualify for a BLE.

The following services are not covered unless the participant qualifies for a Benefit Limit Exception (BLE):

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

A provider may not bill a participant for services that exceed the limits unless the following conditions are met:

- The provider has requested an exception to the limit and the request was denied.
- The provider advised the participant, before the service was provided, that he or she will be responsible for payment if the exception is not granted.
- The provider advised the participant, before the service was provided, that the participant has exceeded the limits.
- The provider advised the participant, before the service was provided, and documented the discussion in the medical record. The provider may have the participant sign an advanced notification form.

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

➢ See *Benefit Limit Exceptions*, UPMC CHC *(*Medical Assistance), Chapter N.

Dental Limits:

- The following dental benefits and limits apply to participants including participants who reside in personal care homes and assisted living facilities.

- The dental limits do not apply to adults who reside in a nursing facility or an intermediate care facility (ICF).

- Services beyond a participant's benefit limits are not covered, unless the participant or the provider requests and receives approval for a **Benefit Limit Exception (BLE)**. The provider cannot bill the participant for the non-covered services unless the participant was advised in advance that the service may not be covered, a BLE was submitted and denied.

Table E1: Dental Limits

Description	Full Benefits	
	(NOT Residing in a Nursing Facility or ICF)	*(Residing in a Nursing Facility or ICF)*
Anesthesia	**Covered** May require prior authorization	**Covered** May require prior authorization
Checkups – (Routine exam) -including x-rays	**Covered - 1 per 180 days** Additional exam requires a BLE	**Covered**
Cleanings - (Prophylaxis)	**Covered - 1 per 180 days** Additional cleanings requires a BLE	**Covered**
Crowns and adjunctive services	**Not Covered** Unless a BLE is approved	**Covered** Requires prior authorization
Dentures *- (One partial upper denture or one full upper denture and one partial lower denture or one full lower denture)*	**Covered - Once per lifetime** Requires prior authorization Additional dentures require a BLE	**Covered – Once per lifetime** Requires prior authorization Additional dentures require a BLE
Dental surgical procedures	**Covered** Requires prior authorization	**Covered** Requires prior authorization
Dental emergencies - (Emergency care)	**Covered**	**Covered**
Extractions *- (Impacted tooth removal)*	**Covered** Requires prior authorization	**Covered** **Requires prior authorization**
Extractions *– (Simple tooth removals)*	**Covered**	**Covered**
Fillings - (Restorations)	**Covered**	**Covered**
Orthodontics - (Braces)	**Not Covered**	**Covered** Requires prior authorization
Palliative care - (Emergency treatment of dental pain)	**Covered**	**Covered**
Periodontal & endodontic services	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
Root canals	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
X-rays	**Covered**	**Covered**
Inpatient hospital, Short Procedure Unit (SPU), or Ambulatory Surgical Center (ASC) dental care	**Covered** Requires prior authorization	**Covered** Requires prior authorization

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.

Refer to the participant's behavioral health managed care organization for coverage of diagnostic services related to mental health and substance abuse.

- See *Mental Health and Substance Abuse Benefits*, UPMC CHC *(*Medical Assistance), Chapter N.
- See UPMC CHC *Behavioral Health Services – Table 8A*, Welcome and Key Contacts, Chapter A.

Closer Look at Laboratory Services

The Department of Human Services requires that a current Clinical Laboratory Improvement Amendments (CLIA) certification be on file with the Office of Medical Assistance Programs (OMAP) for any provider who renders laboratory services to Medical Assistance Recipients. All laboratory testing sites, including physician's offices, are required to have a CLIA certificate. The CLIA certificate and accompanying identification number identify those procedures that the laboratory is qualified to perform.

There are several different types of CLIA certifications:

- Certificate of Waiver (CLIA Waived)
- Certificate of Provider Performed Microscopy Procedures (PPMP)
- Certificate of Registration
- Certificate of Compliance
- Certificate of Accreditation

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are required to submit their CLIA certificates even though they are paid an all-inclusive per encounter payment rate that includes laboratory tests provided at the time of a face-to-face visit. Hospital laboratories are to be Medicare certified or certified by the Pennsylvania Department of Health (DOH) as meeting the standards comparable to those of Medicare.
Out-of-state hospitals do not need to be licensed by DOH but must have current Medicare certification.

- See Medical Assistance Bulletin number: 01-12-67, 08-12-62, 09-12-63, 28-12-01, 31-13-65, 33-13-61, effective January 1, 2013, for additional information.

Education

Participants are eligible for the following health education classes:

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

Closer Look at Education

Contact the **Health Management Department** at **1-866-778-6073** for information on education classes.

Emergency Care

UPMC CHC 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 participant (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 **1-844-849-2926** within 48 hours or on the next business day following an emergency admission

Participants with an emergency medical condition or those acting on the participant'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 participant's PCP or from UPMC CHC.

Redirected Emergency Department Visit

If a participant is instructed by their PCP to come into 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. Such visits are 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 participant with any alternative care arrangements, such as an office visit or treatment instructions.

Hearing Exams/Aids

Hearing exams require a PCP referral. Participants who are eligible for LTSS may qualify for hearing aids.

➢ See *Covered Benefits*, UPMC CHC *(*Medical Assistance), Chapter N.

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
- Registered dietitian services
- Skilled/intermittent nursing
- Speech therapy

Participants who are eligible for LTSS may qualify to receive additional home health benefits.

The provider should contact **Medical Management** for a prior authorization review of medical necessity to receive coverage of home health aide services in the home.

Providers may request prior authorization by logging on to **www.upmchealthplan.com** and entering the authorization request or by calling **1-844-849-2926**. Failure to obtain authorization will result in denial of the claim. If written information is required, it may be sent to:

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

➢ See *Covered Benefits*, UPMC CHC *(*Medical Assistance), Chapter N.

Home Medical Equipment (HME)

Home medical equipment (e.g., 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, e.g., 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 contact **Medical Management** for a prior authorization review of medical necessity to receive coverage of SHME. Providers may request prior authorization by logging onto **www.upmchealthplan.com** and entering the authorization request or by calling **1-844-849-2926**. Failure to obtain authorization will result in denial of the claim.

If Specialized Home Medical equipment needs exceed standard benefit coverage, participants who are eligible for LTSS may qualify to receive additional medical equipment benefits.

➢ See *Covered Benefits*, UPMC CHC *(*Medical Assistance), Chapter N.

Home Physician Visits

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

Hospice Care

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

Hospital Admissions

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

Immunizations

UPMC CHC covers certain adult immunizations. Call **Provider Services** at **1-844-860-9303** for more information.

Mental Health and Substance Abuse Benefits

UPMC CHC does not manage the participant's behavioral health benefits. Mental health and drug and alcohol treatment is available through coordination with Behavioral Health Managed Care Organizations (BH-MCOs). These services include care for those with mental health needs, substance use needs or diagnoses, and those with dual behavioral health diagnoses (mental health and substance use diagnoses). Commonly available services include 24-hour care and rehabilitation for alcohol or other drug problems in a hospital or non-hospital setting, services for detoxification from alcohol or other drugs, outpatient services for substance use treatment, peer-delivered support services, and crisis services as needed. Also included are medication assisted treatment for substance use disorders, for example methadone maintenance or suboxone treatment.

To refer for mental health and drug and alcohol treatment, providers can contact the BH-MCO in participant's county directly. Upon referral, the BH-MCO will coordinate appropriate appointments and/or treatment plans with providers based on specific mental health and drug and alcohol treatment needs and conditions. Participants with LTSS benefits may be eligible for additional benefits. Providers should contact the **Service Coordination department** at **1-844-860-9302 (Southwest Pennsylvania)** or 1-**833-672-8078 (Southeast Pennsylvania)** when coordinating care for participants with LTSS.

Closer Look at Behavioral Health Managed Care Organizations

- See *Table A8: UPMC CHC (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.

Closer Look at Referrals

UPMC CHC **does not require the submission of paper referral forms**. PCPs may refer a participant to a network specialist following standard medical referral practices such as calling the specialist or by providing the participant 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 **1-844-849-2926** for prior authorization approval of an out-of-network referral.

Organ Transplants

Certain organ transplants are covered but require prior authorization from UPMC CHC. Participants 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 CHC participants.

Care for an emergency medical condition, provided by an out-of-network provider, is covered. Participants 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 participant to return to the UPMC CHC service area for treatment and prior authorization is obtained.
- Delay would result in a significant decline in the participant'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 CHC provider network and a prior authorization is obtained.

UPMC CHC participants 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 **1-844-849-2926** 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 and participant will receive written notification. The provider can appeal a denial by following the instructions outlined in the denial letter.

Participants who receive LTSS may be eligible to receive out-of-area services when traveling. Provider or participant should call **Service Coordination** at **1-844-860-9302 (Southwest Pennsylvania)** or **1-833-672-8078 (Southeast Pennsylvania)** for prior authorization.

Alert – Out-of-Network Care Referrals

To send participants to out-of-network specialists or facilities, providers must obtain prior authorization from **Medical Management** by logging onto **www.upmchealthplan.com** and entering the authorization request or by calling **1-844-849-2926**. Failure to get authorization will result in denial of the claim. The referring provider must give the reason for the out-of-network referral. If written information is required, it may be sent to:

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

Alert—Services provided outside of the United States

Emergency and routine care provided outside the United States is 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 participant's PCP and contact **Medical Management** to obtain authorization for procedures as appropriate. Providers may request prior authorization by logging onto **www.upmchealthplan.com** and entering the authorization request or by calling **1-844-849-2926**

Podiatric Care

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

Prescription Drug Coverage

The UPMC CHC prescription plan features a closed, two-tier formulary and mandatory generic utilization, when available. 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. Participants must use the UPMC CHC pharmacy network., Copayments may apply.

➢ See *UPMC CHC 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 CHC participants can receive a 90-day supply of some maintenance medication prescriptions for the cost of one 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 and require prior authorization.

Rehabilitative Therapy

Inpatient

Inpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the participant's PCP and delivered by a network provider. The therapy must be medically necessary and prior authorization must be obtained. The prognosis must indicate t h e potential for improvement.

Outpatient

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

Participants who are eligible for LTSS may qualify to receive additional therapy benefits.

➢ See *Covered Benefits,* UPMC CHC *(*Medical Assistance), Chapter N.

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 or MA-3s)**. This form must be maintained in the participant'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 participant 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 participant:

- Was a victim of rape or incest.
- Reported the incident, including the identity of the offender, if known, to the appropriate law enforcement agency. 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 participant 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 participant may request one through her PCP or ob-gyn provider.

The provider and participant must complete a **Patient Acknowledgement for Hysterectomy form (MA-30)**. The consent form must be maintained in the participant'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 participant must voluntarily give informed consent to the procedure. The participant also must sign a Sterilization Consent form (MA-31 or MA-31s) at least 30 days, but no more than 180 days, before the procedure to receive coverage. The consent form must be maintained in the participant'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 participant must voluntarily give informed consent to the procedure. The participant also must sign a Sterilization Consent form (MA-31) at least 30 days, but no more than 180 days, before the procedure to receive coverage. The consent form must be maintained in the participant's medical record and a copy of the form must be submitted with the claim.

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 participant 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 by UPMC CHC. The out-of-network provider must obtain prior authorization by contacting **Medical Management at 1-844-849-2926**

Therapy

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

Urgent Care

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

Urgent care is covered when the participant 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 Cases of Rape and Incest

In cases of rape or incest, the participant 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 participant:

- Was a victim of rape or incest.
- Reported the incident, including the identity of the offender, if known, to the appropriate law enforcement agency.
- 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.

Closer Look at Urgent Care

If the participant is unable to call the PCP before going to the emergency department and the participant 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 participant should attempt to contact **Provider Services** at **1-844-860- 9303.** If the emergency department cannot reach UPMC CHC, it should provide the service and attempt to contact the PCP or UPMC CHC afterward.

Routine Vision Benefits

Routine Vision benefits are provided by **Envolve Vision, Inc**. Benefit coverage may vary. Contact the UPMC Health Care Concierge Team with questions at **1-844-833-0523**.

Participants receive:

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

Women's Health

Routine Ob-Gyn Services

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

Non-routine Ob-Gyn Services

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

Family Planning

Participants 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 CHC participants may access, at a minimum, 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), implants, injectables, intrauterine devices, and other family planning procedures.

Closer Look at Family Planning

UPMC CHC 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 CHC will coordinate benefits.

Pregnancy Care

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

- **NOTE**: UPMC CHC enrolls pregnant participants in the UPMC Health Plan Maternity Program, which assesses pregnancy risks and offers participants several prenatal services.

Health coaches* provide education by telephone and coordination of care with an emphasis on the psychosocial and socioeconomic issues that could affect a pregnancy. They are available to answer participants' questions and offer support and advice between their visits.

Closer Look at Health Coaches*

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.

Obstetrical Needs Assessment Form (ONAF)

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

Closer Look at Maternity-Related Forms and Tools

Obstetrical Needs Assessment Form (ONAF)

Providers should complete the ONAF, and fax it to 412-454-8558. For questions about the form, or to obtain forms, providers may call the **maternity program** at **1-866-778-6073.**

Depression Screening Tools

Providers are required to screen pregnant participants for depression both prenatally and post-partum using one of the 2013 DHS validated depression tools. Forms, tools, and instructions are also available online in the Medical Prior Authorization Resources section at **www.upmchealthplan.com/providers/medmgmt.html**

- See *The Maternity Program*, Medical Management, Chapter G
- See *Other Resources and Forms*, UPMC CHC (Medical Assistance), Chapter N.

Linguistic and Disability Competency

In addition to Title VI compliance and ADA accessibility requirements outlined in Section B of this manual, CHC providers must also comply with the following minimum requirements as appropriate to their setting and services

- Participants with physical disabilities (including those who use wheelchairs) must be able to independently access Provider's office via accessible route from parking lot or public transportation (includes being able to open doors, traverse sidewalks and entrances, approach check-in desk, enter exam room, etc.)
- Participants with physical disabilities (including those who use wheelchairs) must be able to access and use a restroom within the building in which Provider's office is located (preferably within Provider's office or suite)
- Provider must allow for extended appointment times to accommodate disability and communication need
- Provider must provide foreign language, American Sign Language (ASL) and tactile interpreters upon request via onsite or video remote/over the phone interpreters
- Provider must ask participants at time of appointment scheduling if any disability or communication accommodations will be needed for the participant's visit
- Providers must allow service animals to accommodate participants and visitors during appointments
- Providers must provide participants with written communication in an alternative format upon request (Braille, large print, foreign language, audio, etc.)
- Provider must respond to disability complaints in a timely manner and keep record of such complaints

ASL and foreign language interpreters should be scheduled in advance of participant appointments and home visits. Providers who welcome participants to their facilities and offices are encouraged to have access to Video Remote Interpreting (VRI) Services.

For additional information about interpreters, VRI or other disability-related accommodations, contact **UPMC's Disabilities Resource Center** at **412-605-1483** or **disabilitiesresource@upmc.edu**. For assistance, contact **Provider Services** at **1-844-860-9303**

A Closer Look at Alternative Format Documentation

It is the provider's responsibility to provide alternative format documents to participants who cannot utilize standard written communication. This includes all forms of written communication and may include formats such as foreign language, audio, braille and large print. Audio, braille and large print formats can be obtained from the PA Association for the Blind.

All providers are required to demonstrate cultural, linguistic and disability competency by providing reasonable accommodations, using appropriate language when speaking to and about people with disabilities, and understanding barriers to accessing services such as transportation, communication, scheduling, attitudinal bias and structural inaccessibility. Cultural, linguistic and disability competency training will be provided during orientation.

Competency will be monitored and measured via on-site accessibility assessments, review of complaints and grievances and ongoing follow up by UPMC's Provider Network Department. Questions regarding cultural, linguistic and disability competency can be asked via **CHC's Provider Services** at **1-844-860-9303**

Other Services

Other services available to UPMC CHC participants include the following:

Health Management Programs—UPMC CHC offers several health management programs, including asthma, cardiovascular disease (coronary artery disease and congestive heart failure), chronic obstructive pulmonary disease, and diabetes at no cost to the participant. Health coaches are available to answer participants' questions and offer support and advice between their visits. Information about the programs is available at **1-866-778-6073** from 7 a.m. to 8 p.m. Monday through Friday and 8 a.m. to 3 p.m. on Saturday.

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

The goals are to improve clinical outcomes and quality of life. The program is structured to identify participants with chronic conditions, conduct outreach, assess participants' needs, develop a coordinated care plan that is created with participants' input, and monitor participants' progress with that plan. An assessment of participants' medical and behavioral health, compliance status, use of self-monitoring tools, and their understanding of the condition are completed to determine areas for focused education or care coordination. All interventions are aimed at increasing participants' knowledge of their condition and improving their ability to manage their disease.

A specialized team of health coaches (nurses, social workers, dietitians, exercise physiologists, counselors, and health educators), in collaboration with the participants' providers, work to accomplish these goals through participant education, coordination of care, and timely treatment.

In addition, these programs provide help for participants 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. There are also programs to assist with lifestyle risk goals such as smoking cessation, weight management, nutrition, stress management, and physical exercise. Participants enrolled in these programs receive educational materials and have frequent clinical sessions with their health coach.

Providers who serve participants who would benefit from these health management programs should contact **Health Managemen**t 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 to 3 p.m.

Additional information on health management programs can be found online at www.upmchealthplan.com in the Provider section under Patient Health.

UPMC *My*Health 24/7 Nurse Line—A round-the-clock advice line for participants seeking general health advice or information regarding a specific medical issue. Experienced registered nurses are available 24/7 provide participants with prompt and efficient services. The UPMC *My*Health 24/7 Nurse Line is available for medical questions concerning both adults and children. The participant may call **1-866-918-1591.** TTY users should call toll-free **1-866-918-1593.**

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

If a participant, upon enrolling in UPMC CHC, is receiving services authorized by another Physical Health Managed Care Organization (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 depending on if the participant is pregnant. However, the provider still must notify UPMC CHC with information regarding those services. Contact **Medical Management** at **1-844-849-2926.**

The participant will continue to receive any prior authorized service up to sixty (60) days after enrollment with UPMC CHC. 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 participants who are pregnant:
If a pregnant participant is already receiving care from an out-of-network ob-gyn provider at the time of enrollment, the participant 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, review standards for prior authorization and referral requirements

➢ See *Services requiring Prior Authorization*, Medical Management, Chapter G.

If a participant, upon enrolling in UPMC CHC on the MCO's initial start date in participant's zone, is receiving LTSS services authorized by another Service Coordination entity, or by the Medical Assistance fee-for- service program, those services will continue for at least 180 days, known as the Continuity of Care period. If a participant is receiving LTSS services authorized by another Service Coordination entity and chooses to change MCOs, those services will continue for 60 days or until a comprehensive needs assessment has been completed and a person-centered service plan (PCSP) has been developed and implemented, whichever date is later.

Questions regarding continuity of care can be directed to **Provider Services** at **1-844-860-9303**.

Services Not Covered

The following services are not covered under the UPMC CHC program unless pre-approved (prior authorized) by **Medical Management.** Contact Medical Management by calling **1-844-849-2926** to determine if a service is eligible to be considered for a prior authorization:

- Acupuncture
- Experimental or investigative treatments
- Home and vehicle modifications (CHC participants with LTSS may be eligible for this service. See Covered Services for more information or call **Provider Services** at **1-844-860-9303**.
- 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 participant
- 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. CHC participants with LTSS may be eligible for certain self-directed care. See Covered Services for more information or contact Provider Services at 1-844-860-9303.

➢ See *Coordinated Care*, UPMC CHC *(*Medical Assistance), Chapter N.

Program Exception Process

The program exception process occurs when a provider requests Medical Management review of a service that is not a covered benefit to determine if an exception should be made based on medical necessity. The process also applies to benefit limit exception requests for additional treatment for a participant 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 CHC participants.

Providers may submit exception requests for benefit limit to **Medical Management** by calling **1-844-849-2926** faxing to **412-454-2057**, or sending a letter to:

UPMC Health Plan
Attn: Medical Management
U.S. Steel Tower, 11th floor
600 Grant Street
Pittsburgh, PA 15219

A provider or the UPMC CHC participant must submit the following information to request an exception:

- Participant's name
- Participant's address and telephone number
- Participant's UPMC CHC participant ID
- A description of the service for which the provider or the participant is requesting an exception
- The reason the exception is necessary
- The provider's name and telephone number

The provider or participant may request a benefit limit exception before or after the service has been delivered.

For an exception request made before the service has been delivered, UPMC CHC will respond within 21 days upon receipt of the request. If the provider indicates an urgent need for a quick response, UPMC CHC will respond within 48 hours upon receipt of the request. For an exception request after the service has been delivered, UPMC CHC 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 CHC 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 participant liable for payment and bill the participant for services that exceed the limits unless the following conditions are met:

- The provider advised the participant, before the service was provided, that the participant has exceeded the limits.
- The provider advised the participant, 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 for a UPMC CHC participant, the provider should submit a request to Medical Management and offer supporting information demonstrating the medical necessity of the exception.

When a participant 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 participant.

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,

If the provider's request is for the continuation of services that the participant 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 participant the opportunity to appeal the decision. If the participant 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 Benefit Limit Exceptions

Benefit Limit Exception:

An exception to service limits may be granted if the UPMC CHC participant:

- Has a serious chronic illness or other serious health condition, and without the additional service, the participant's life would be in danger; or health will get much worse; or
- Needs a costlier service if the exception is not granted
- It would be against federal law for UPMC Community HealthChoices to deny the exception

Dental Benefit Limit Exception:

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

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

Service Coordination

Role of Service Coordinators

Service coordinators are qualified individuals (nurses, social workers, or those with experience serving the waiver populations and hold a bachelor's degree) who are the accountable point of contact for each participant.

The service coordinator's role includes the following activities:

- Provide information about available services, needs assessments and the Person-Centered Service Plan (PCSP) process.
- Identify, locate, coordinate, and assist participants to gain access to needed LTSS, physical health and behavioral health services.
- Inform participants about service alternatives and delivery options including choice of service providers as well as opportunities for self-direction.
- Conduct person-centered, Comprehensive Needs Assessments, and develop PCSPs and Care Plans.
- Oversee the implementation of PCSPs.
- Assist with durable medical equipment (DME), pharmacy, and ancillary services (e.g., dental, physical therapy).
- Arrange and schedule transportation to covered medical services through the Medical Assistance Transportation Program (MATP) as well as non-medical transportation to appointments, activities and resources as identified on the PCSP.
- Promote wellness and encourage the utilization of preventative care services.
- Provide education to caregivers based on the participant's condition including symptoms and/or triggers of changing health and functional status and appropriate actions to take.
- Coordinate efforts and prompt participants to complete redetermination process to maintain Medical Assistance eligibility.
- Assist participants on the appeals and grievances processes as well as providing information about participants' rights including DHS Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests as needed.

For more information or to speak with a service coordinator, contact **Service Coordination** at **1-844-860-9302 (Southwest Pennsylvania)** or **1-833-672-8078 (Southeast Pennsylvania)**

Role of the Provider for Participants who receive LTSS

Providers have an integral role in the goal of seamless and continuous, participant-centric care. To help achieve that goal, both medical and non-medical providers should:

- Actively engage with the participant's service coordinator to facilitate appointments, referrals, and treatment needs.
- Be aware of the services a participant receives and any gaps in care identified on the PCSP.
- Communicate and work with the participant to identify needs not identified on the PCSP.
- Provide care focused on prevention, improvement, and sustainment of health outcomes and independent living of the participant.
- Be an active and collaborative participant of the Person-Centered Planning Team (PCPT) to better understand and address the participant's needs.

It is important that providers engage with service coordinators when they are aware of a change in the participant's life that may impact or require updates to the PCSP for optimal health outcomes.

Examples of changes or situations that would prompt providers to engage with services coordinators include but are not limited to:

- Participants that have experienced a change in functional status or are given a new diagnosis.
- Participants admitted, transferred, or discharged to a hospital or nursing facility.
- Participants who need additional home services, adaptive devices, or adaptations.
- Participants that are not compliant with preventative or ongoing medical services.
- Providers have a concern about participant's living situation or home environment.
- Providers have noted a change in the participant's mood or behavior.

In addition to these changes, providers must report any suspected abuse and neglect through the appropriate channels.

➢ See *Critical Incident Reporting*, Community HealthChoices Chapter N

Every participant has the right to choose or change their own provider for medical and non-medical services. Committed coordination and involvement in the participant's PCPT may decrease such changes and lead to more consistent care and services.

Person-Centered Planning Teams

A Person-Centered Planning Team is a group of people that includes the participant, who collaboratively work together to coordinate care, minimize service disruption, and provide the broad expertise needed to help participants with diverse and often complex conditions achieve their desired outcomes.

The PCPT is led by the participant (or designated representative) to direct the process of his or her services to the maximum extent possible. The participant selects the people that make up the PCPT for the overall planning of service delivery. The PCPT may include family member, alternative care givers, neighbors, friends, and providers such as the Primary Care Provider or servicing providers, and anyone else the participant chooses to be a part of their overall care.

The PCPT approach encourages and supports the participant to direct the process and to make informed choices and decisions. The PCPT works together to develop the PCSP, which includes the overall coordination of physical, behavioral, and support services as well as any goals and preferences expressed by the participant.

The service coordinator initiates the PCPT, provides any training needed on PCPT participation, and facilitates service plan assignments necessary in support of the participant. The service coordinator communicates with the PCPT as necessary to provide seamless coordination and limit disruption of services for the participant.

Comprehensive Needs Assessment and Reassessment

A Comprehensive Needs Assessment is completed for all participants that are Nursing Facility Clinically Eligible (NFCE). A Comprehensive Needs Assessment may also be completed for participants that are not NFCE, but the participant requests a needs assessment, self-identifies as needing LTSS, or is identified as having unmet needs, service gaps, or a need for service coordination.

An assessment is conducted in-person in the participant's home or primary residence, at a date and time convenient to the participant. Through the assessment, and subsequent reassessments, the service coordinators assess a participant's physical, behavioral, social, psychosocial, functional, environmental, and LTSS needs.

Service coordinators also assess the participant's caregiver(s) and/or natural/informal support system. Throughout the assessment process, service coordinators identify the participant's preferences and goals to develop the Person-Centered Service Plan and Care Plan with the participant's participation.

The assessment is comprised of key elements to identify and evaluate the participant's needs including:

- Need for comprehensive care management or disease management of chronic conditions.
- Functional and/or cognitive limitations in performing ADL/IADLs, and support level needed.
- Ability to manage and direct finances and services independently.
- Level of supervision required
- Supports for natural or unpaid caregivers.
- Assessment of the participant's or caregiver's health and safety risks.
- Environmental challenges, including housing, to promote independence and safety
- Availability of able and willing informal supports.
- Use of, or need for, adaptive devices.
- Preferences/goals for community engagement, employment, and/or education.
- Additional information gathered during the assessment that is not included in the tool but supplements the overall participant assessment.
- Diagnoses, ongoing treatments and medications

Reassessments are conducted no more than 12 months following the previous assessment, unless there has been a recent and unplanned event such as a significant change in functional status or diagnosis, change in informal supports, or a change in the home environment.

In the event of a hospital discharge, a reassessment occurs within 48 business hours from the time the service coordinator is made aware of the discharge.

Reassessments are also conducted if the participant, caregiver, designated representative, provider, PCPT, or the Pennsylvania Department of Human Services requests a reassessment. In such case, a reassessment is conducted within 14 days of notification of the event or request for reassessment.

Person-Centered Service Plans (PCSP)

The PCSP is a written, holistic approach to addressing the participant's physical, cognitive, behavioral, social, and environmental needs. It is created no more than 30 days from the date of the Comprehensive Needs Assessment. The PCSP is created with the participant or designated representative in a culturally and linguistically appropriate manner that fully incorporates the participant's preferences, strengths, goals, and expectations for their services. Service coordinators assist the participant in making informed choices about their services and getting access to covered services identified in the PCSP. The participant has a right to request updates to the PCSP as needed.

The PCSP is comprised of two key components: The Care Plan and the Service Plan

Care Plan:
Service coordinators develop a holistic Care Plan that identifies and addresses how the participant's physical, cognitive, behavioral, social, environmental, and functional needs are addressed and coordinated. **The Care Plan includes**:

- Chronic and non-chronic conditions including recent exacerbated conditions and disease management action steps.
- Cognitive needs.
- Current medications.
- All services authorized including the scope and duration of the services authorized.
- Needed physical and behavioral health care and services, including preventative care or requirements and a plan to coordinate the participant's Medicare, Veteran's benefits, behavioral health benefits, Lottery-funded services, and other health coverage as needed.
- All designated points of contact authorized by the participant who may request/receive information about the participant's services.

Service Plan:
The Service Plan documents all services necessary to support the participant to live as independently as possible and be engaged in the community as much possible. **The Service Plan includes:**

- All needs and preferences identified in the assessment including interventions, reasonable long and short-term goals, and measurable outcomes with anticipated time lines.
- Potential problems and how to minimize risks to foster a maximum functioning level of well-being.
- The participant's choice of service providers, including the participant's decisions about their service delivery model including Self-Directed care.
- A communications plan and individualized back-up plans, including a list of informal supports and services that are available, willing, and able to assist the participant.
- How frequently specific services will be provided.
- Any telehealth or other technology used to assist the participant.
- The person responsible for conducting interventions and monitoring outcomes, such as the service coordinator or a participant of the PCPT.
- A plan for the participant to access community resources, non-covered services and other supports including how to accommodate preferences for leisure activities, hobbies, community engagement, employment, and education goals.

Provider Critical Incident Reporting Requirements

Reporting Requirements

UPMC Community HealthChoices requires all network providers to report all Critical Incidents involving UPMC CHC participants to the participant's Service Coordinator within 24 hours of discovery, and after assuring the health and safety of the participant. For all incidents that meet the state's criteria for critical incidents, the direct service providers must report the incidents in the state's Enterprise Incident Management (EIM) system within 48 hours. All investigations and follow up activities must be completed and documented in EIM within 30 days. Other providers may submit a typed critical incident form that is available on the Provider Services website **(www.upmchealthplan.com/providers/hcbs/resources)** to **chc_critical@upmc.edu** within 24 hours from the date of discovery and UPMC CHC will submit the incident in the state's EIM system. Any type of provider may use the online form as an alternative reporting method if the EIM system is not working.

Requesting EIM access

Direct Service Providers must designate two people in their agency to become Administrators for the EIM system. These system administrators will be responsible for developing EIM user accounts for other designated people in their agency who will report critical incidents when they occur. Information and a request form for EIM access can be requested through **chc_critical@upmc.edu.** If a provider already has EIM access, they do not need to complete this next step.

Training

Providers must participate in an EIM training to learn about the changes made to the system for Community HealthChoices participants. Providers will have access to training webinars and education materials through the UMPC CHC Provider Services website. Providers must participate in trainings offered by UMPC CHC to ensure accurate and timely reporting all critical incidents. Trainings may be offered at webinars, online or in person at regional meetings.

Critical Incidents Categories

The following categories of incidents are considered reportable:

- **Death** (if suspicious in nature or unexpected only);
- **Serious injury** that results in emergency room visits, hospitalizations, or death;
- **Unplanned Hospitalization**
- **Provider or staff misconduct**, including deliberate, willful, unlawful, or dishonest activities;
- **Emergency Room visits**

- **Abuse**, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
    - *Physical abuse,* defined as a physical act by an individual that may cause physical injury to a participant;
    - *Psychological abuse*, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
    - *Sexual abuse*, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
    - *Verbal abuse*, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant.
- **Neglect,** which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.
    - *Seclusion,* which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
    - *Abandonment,* which is the desertion by anyone who assumed caregiving responsibilities for a CHC participant.
- **Exploitation**, which is an act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;
- **Restraint**, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
- **Service interruption**, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
- **Medication errors** that result in hospitalization, an emergency room visit or other medical intervention.

PSAE

- Any Preventable Serious Adverse Event (PSAE) discovered in a nursing facility must be reported in compliance with **PA Bulletin 03-14-08 issued 09/13/2014**. The facility must also notify the MCO on the claim and email it to **hpqualityreview@upmc.edu**.

Immediate First Steps for Suspected Abuse, Neglect, Exploitation Incidents

Any provider, service coordinator, subcontractor, or UPMC employee who observes or has reasonable cause to **suspect abuse, neglect, exploitation, abandonment, or suspicious or unexpected death** has occurred with a CHC participant are mandatory reporters and must:

1. **Take immediate action to assure the participant's health and safety**. If the participant's health or well-being is in imminent danger, notify emergency first responders **(9-1-1)**.
2. **Make a verbal report** to the state **Adult Protective Services Hotline** at **1-800-490-8505**. Any questions requiring immediate attention outside of regular business hours should be directed to the APS contractor - Liberty Healthcare's on call staff at **1-888-243-6561**. Please note this number should **only be used for emergency situations** requiring immediate attention.
3. **Then call the participant's UPMC-CHC Service Coordinator** within 24 hours, if that number can be located. If there is no answer, then:

   Make a verbal report to UMPC CHC Health Care Concierge Team at **1-844-833-0523** within 24 hours.

   - At a minimum, the verbal report must include participant's full name, date of birth, date and time of incident, a brief description of the incident, participant's current condition, and actions taken to mitigate risk to the participant; and
   - The reporter's name, agency, and contact information.
4. **Submit a critical incident report** to the state's EIM System

Possible Actions Needed After an Incident

To protect the safety of the participant, actions that can be taken immediately by a provider include but are not limited to the following:

- Contact **9-1-1** if the incident can cause or did cause immediate/severe harm to the participant
- Remove worker from the participant's services (if incident includes allegation of improper behavior by that worker)
- Remove accused worker from servicing any UPMC CHC participant until the investigation is complete. This may take up to 30 calendar days.
- Interview involved employee(s) as soon as possible following the incident.
- Have the employee(s) submit a written account of events.
  - Electronically submit these written accounts to **chc_critical@upmc.edu**
- Fax numbers, phone numbers, or email addresses for UPMC CHC staff can be obtained by calling **UPMC CHC Health Care Concierge Team** at **1-844-833-0523.**

Follow-Up Responsibilities

Providers must cooperate fully in the investigation of reported critical incidents, including submitting all requested documentation within timelines specified. If the incident involves an employee of a HCBS provider, the provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident.

Based upon the severity of the incident, any identified trend or failure on the part of the provider to cooperate with any part of the investigation, the provider may be required by UPMC to submit a written plan of correction to address and correct any problem or deficiency surrounding the critical incident. Corrective Action Plan templates can be found **on the UMPC CHC Provider Services website at www.upmchealthplan.com/providers.**

MA Provider Compliance Hotline

If you have knowledge of suspected MA provider noncompliance, or of substandard quality of care for services paid for under the Pennsylvania Medical Assistance Program, please contact the **MA Provider Compliance Hotline** by calling **1-866-379-8477**. Reported problems will be referred to the Office of Administration's Bureau of Program Integrity for investigation, analysis and determination of the appropriate course of action.

Participant Complaint and Grievance Procedures

UPMC CHC participants have a complaint, grievance, and fair hearing process available to them if they are unhappy about services provided by UPMC CHC or their provider. The participant may ask his or her provider to file a complaint on their behalf, but they must officially appoint the provider as their personal representative in writing.

For a detailed summary of the participant Complaint and Grievance Procedures, please see the UPMC Community HealthChoices Participant Handbook at: **www.upmchealthplan.com/chc/members/documents-and-resources.**

For an expedited complaint or grievance, the provider must indicate in writing that a participant's life or health is at risk. UPMC CHC will send a letter within 48 hours of receiving the Provider certification or 3 business days of receiving the Participant's request for an expedited review, whichever is sooner, informing the participant of its decision.

The UPMC CHC Participant complaint, grievance and fair hearing process is separate and distinct from the Provider Dispute process outlined in Chapter B, Provider Standards and Procedures.

Other Resources and Forms

www.upmchealthplan.com/providers/medical/resources/guidelines/clinical-practice.aspx

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

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

- **See Medical Prior Authorization Resources section**

- Patient Health Guidelines
- Physician Forms
  - Obstetrical Needs Assessment form
  - 2013 DHS-validated depression screening tools

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

- UPMC Health Plan Quick Reference Guides (QRGs) provide a snapshot of prior authorization and referral requirements.

Copayment Schedule

UPMC CHC participants do not have Medicaid copayments for services and medical equipment received. Participants are subject to Medicaid pharmacy copayments. If participant is dual eligible, participant is still responsible for all Medicare copayments for pharmacy services.

Table N2: Copayments Schedule

	Adult Medical Assistance Participants
Services	**Copay**
Ambulance (per trip)	$0
Dental Care	$0
Per Day	$0
Maximum with Limits	$0
Emergency Department (non-emergent visits)	$0
Ambulatory Surgical Center	$0
Federal Qualified Health Center Regional Health Center	$0
Convenience Care or Urgent Care Centers	$0
Short procedure unit	$0
Purchase	$0
Rental	$0
Certified nurse practitioner	$0
Chiropractor	$0
Doctor (PCP- OB/GYN)	$0
Optometrist	$0
Podiatrist	$0
Therapy, (Occupational, Physical, Speech)	$0
Per Visit	$0
Generic	$0
Brand	$3
Medical diagnostic testing (per service)	$0
Radiology diagnostic testing (per service)	$0
Nuclear Medicine (per service)	$0
Radiation Therapy (per service)	$0