UPMC *for You*

(Medical Assistance)

At a Glance

UPMC *for You*, affiliate of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in 40 counties in the Commonwealth of Pennsylvania. This care is achieved by combining the benefits of a managed care organization with all the services covered by Medical Assistance. All UPMC *for You* providers must abide by the rules and regulations set forth under the General Provision of 55 Pa. Code, Chapter 1101.

Alert—Department of 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 **1-866-918-1595** or visit **www.upmchealthplan.com**.

If providers have questions regarding UPMC *for You* coverage, policies, or procedures that are not addressed in this manual, they may call **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

Medical Assistance Managed Care in Pennsylvania

Pennsylvania's Department of Human Services (DHS) contracts with managed care organizations across Pennsylvania to offer managed care to recipients of Medical Assistance under a program called HealthChoices.

HealthChoices

HealthChoices is Pennsylvania's innovative mandatory managed care program for Medical Assistance recipients. Recipients choose among physical health managed care organizations (PH-MCOs) contracted with DHS to provide at least the same level of services as offered by ACCESS, the traditional fee-for-service program. Behavioral health services are provided by behavioral health managed care organizations (BH-MCO) that contract with DHS.

➢ See UPMC *for You Contacts, Behavioral Health - Table A5*, Welcome and Key Contacts, Chapter A.

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

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

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

Covered Benefits

At a Glance

UPMC *for You* network providers supply a variety of medical benefits and services, some of which are listed below or itemized on the following pages. For specific information not covered in this manual, call **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

Key Points

UPMC *for You* covers:

- Medical services
- PCP visits.
- General medical exams or office visits for obtaining a driver's license, or for participating in sports and/or camps.
- Specialist visits with a verbal referral and coordinated by a PCP (*copayments may apply to chiropractor and podiatrist visits*).
- Emergency services.
- Prenatal care.
- Counseling to stop smoking or using other tobacco products.
- Inpatient (acute or rehab) services
- Outpatient hospital services, ambulatory surgical center, or short procedure unit (copayments may apply).
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Members **younger than 21 years old**. (including immunizations/vaccines).
- Medically necessary services for Member **younger than 21 years old**.
- Allergy tests and injections.
- Laboratory services.
- X-rays, radiation therapy, cardiograms, and other diagnostic tests
- Physical, occupational, and speech therapy
- Cancer treatments.

- Nutritional counseling.
- Kidney dialysis.
- Home healthcare – intermittent skilled nursing visits to perform services such as wound care and dressing changes.
- Home health aide – personal care services for members **under the age of 21** (requires prior authorization).
- Medical equipment and supplies.
- Hearing aids for Members **younger than 21 years old**.
- Private duty nursing-skilled nursing services for Member **younger than 21 years old** (requires prior authorization).
- Hospice.
- Gender affirming services.

Coordinated Care

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

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

To verify the coverage of any service, please contact **Provider Services** at **1-866-918-1595** or visit **www.upmchealthplan.com**.

All payments made to providers by UPMC *for You* constitute full reimbursement to the provider for covered services rendered. Please refer to the provider contract for specific fee schedules. If UPMC *for You* imposes copayments for certain covered services and a Member cannot afford to pay the copayment at the time of the service, providers must render covered services to the Member despite nonpayment of the copayment by the Member. This shall not preclude providers from seeking payment for the copayments from Members after rendering covered services.

Closer Look at a Primary Insurance Copayments

If the Member has a primary insurance and there is a copayment, coinsurance or a deductible due from the Member, that amount is included in the coordination of benefits calculation.

- If the primary insurance's payment is greater than the UPMC *for You* fee schedule payment, the provider must accept the primary insurance payment as payment in full. The Member would not be responsible for the amounts applied to a copayment, coinsurance or deductible by the primary insurance.

- If the primary carrier's payment is less than the fee schedule, UPMC *for You* will coordinate benefits and pay up to the fee schedule amount. The provider is required to accept the payment as payment in full. The Member would not be liable for any copayment, coinsurance or deductible applied by the primary insurance.

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

- of the nature of the service;
- that the service is not covered by UPMC *for You* and UPMC *for You* will not pay for the service; and
- provides an estimate of the cost to the Member for the service.

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

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

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

- A Member's average office waiting time for an appointment for routine care is no more than **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 Member with a difficult medical need.

Ambulance

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

All requests for medically necessary nonemergency 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
- Invalid coach
- Wheelchair van transportation

Closer Look at Routine Medical Transportation

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

If the Member has an unusual nonemergency transportation need due to a medical condition, the Special Needs Department can be contacted for assistance. The **Special Needs Department** can be reached Monday through Friday 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m. by calling **1-866-463-1462**.

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

Ancillary Services

Ancillary services are covered when coordinated by a participating provider and rendered by a participating provider for medically necessary services covered by the Medical Assistance fee schedule. Some services may have copayments and require prior authorization review.

➢ See Procedures Requiring Prior Authorization, Utilization Management and Medical Management, Chapter G.

Chiropractic Care

UPMC *for You* Members may self-direct to chiropractic care. Chiropractic services are covered when delivered by a network provider. UPMC *for You* covers only **one evaluation per year** and medically necessary manual spinal manipulations. For children **younger than 13 years old**, the Member's PCP should coordinate chiropractic services. Children **13 years old and younger** need prior authorization for chiropractic services.

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

Copayments may apply for some Members **18 years old and older**.

➢ See *Copayment Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

Dental Care

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

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

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

Dental services for members 21 years old and older

UPMC *for You* Members who are **21 years old and older** and do not live in a nursing home or intermediate care facility (ICF) are eligible for the following services:

- One dental exam (oral evaluation) and cleaning (prophylaxis), every **180 days**.
  - *Additional oral evaluations and prophylaxis will require a benefit limit exception (BLE).*

- One partial upper denture or one full upper denture; and one partial lower denture or one full lower denture.
  - *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 Member can only receive another partial or full upper denture if they qualify for a BLE.

  - **NOTE:** If UPMC *for You* paid for a partial or full **lower denture** since April 27, 2015, the Member can only receive another partial or full lower denture if they qualify for a BLE.

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

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

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

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

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

Dental limits for Members 21 years old and older:

- The following dental benefits and limits apply to Members, **21 years old and older**, including Members **21 years old and older** who reside in personal care homes and assisted living facilities.

- The dental limits do not apply to Members **younger than 21 years old** or to adults who reside in a nursing facility or an intermediate care facility (ICF).

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

Table E1: Dental Limits for Members 21 Years Old and Older

Description	Full Benefits	
	Age 21 and older ***(NOT Residing in a Nursing Facility or ICF)***	**Age 21 and older** ***(Residing in a Nursing Facility or ICF)***
Anesthesia	Covered May require prior authorization or subject to retrospective review	Covered May require prior authorization or subject to retrospective review
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 require 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

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

** Exceptions to the periodontal limits with be granted for individuals who have specials needs or a disability, pregnant women, individuals with coronary artery disease, or individuals with diabetes.

*** Medically necessary dental care such as:

- Oral surgery and impacted teeth removal if the nature of the procedure or the Member's compromising condition would cause undue risk if performed on an outpatient basis.
- Teeth extraction and dental restorative services for a Member who is unmanageable and requires general anesthesia by an anesthesiologist, due to a severe mental and/or physical condition.

Dental service for Members younger than 21 years old

The following dental services are covered for Members **younger than 21 years old** when medically necessary:

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

Closer Look at Braces

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

Members **younger than 21 years old** are eligible to receive all medically necessary dental services. The American Dental Association and the American Academy of Pediatric Dentistry state that the first dental visit should occur **within six months** after the child's first tooth eruption but **no later than their first birthday**. The Member should be referred to a dental home as part of their EPSDT well-child screenings. Providers should notify the Special Needs Department of the referral utilizing the Dental Referral Fax form. Staff will then contact the Member or parent to schedule an appointment and send a reminder **24 to 48 hours** prior to the appointment.

- See *The EPSDT Program*, UPMC *for You (*Medical Assistance), Chapter E.
- See *Other Resources and Forms*, UPMC *for You* (Medical Assistance), Chapter E.

The Department of Human Services' pediatric dental periodicity schedule provides recommendations for preventive dental care and screening recommendations for children, infancy **through 20 years old**, for the following:

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

➢ See *Other Resources and Forms*, UPMC *for You* (Medical Assistance), Chapter E.

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

All EPSDT screens are covered for Members **younger than 21 years old** and are based on the EPSDT Periodicity Schedule.

➢ See *The EPSDT Program*, UPMC *for You (*Medical Assistance), Chapter E.
➢ See *Other Resources and Forms, EPSDT Periodicity Schedule*, UPMC *for You (*Medical Assistance), Chapter E.
➢ See *Other Resources and Forms, Preventive Pediatric Oral Health Care Periodicity Recommendations*, (Dental Periodicity Schedule), UPMC *for You* (Medical Assistance), Chapter E.

Diagnostic Services

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

➢ See *Copayment Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

Refer to the Member'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 *for You (*Medical Assistance), Chapter E.
➢ See UPMC *for You Contacts-Behavioral Health Services – Table A5*, 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 must 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 be currently Medicare certified.

➢ 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

Members 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 *for You* will cover care for emergency medical conditions with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member (or for pregnant women, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Closer Look at Emergency Care

The hospital or facility must contact **Utilization Management** by accessing **Provider OnLine** at **www.upmchealthplan.com/proivders** within **48 hours** or on **the next business day** following an emergency admission.

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

Redirected Emergency Department Visit

If a Member is instructed 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 Member with any alternative care arrangements, such as an office visit or treatment instructions.

Family Planning

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

Closer Look at Family Planning

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

Hearing Exams/Aids

Hearing exams require a PCP referral. Hearing aids are covered for UPMC *for You* Members **younger than 21 years old** when provided by a network provider.

Home Health Care

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

- Home health aides – *requires prior authorization*
- Home infusion therapy
- Medical social services
- Occupational therapy
- Physical therapy
- Private duty nursing in the home (for Members **younger than 21 years old**) – *requires prior authorization*
- Registered dietitian services
- Skilled/Intermittent nursing
- Speech therapy

The provider must contact **Utilization Management** for a prior authorization review of medical necessity to receive coverage of private duty nursing services or home health aide services in the home.

Providers may request prior authorization by submitting the authorization request through **Provider OnLine** at **www.upmchealthplan.com/providers**. Failure to obtain authorization will result in denial of the claim. If written information is required, it may be sent to:

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

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.

SHME 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 **Utilization Management** for a prior authorization review of medical necessity to receive coverage of SHME. Providers may request prior authorization by submitting the authorization request through **Provider OnLine** at **www.upmchealthplan.com/providers.** Failure to obtain authorization will result in denial of the claim.

Home Physician Visits

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

Hospice Care

Hospice care is available for a terminal diagnosis with a prognosis of **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 *for You*. If a specialist admits the patient, the specialist should coordinate care with the Member's PCP. Some UPMC *for You* Members **18 years old or older** may have a copayment for inpatient stays.

➢ See *Copayment Schedule,* UPMC *for You (*Medical Assistance), Chapter E.

Immunizations

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

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

UPMC *for You* also covers certain adult immunizations. Call **Provider Services** at **1-866-918-1595** for more information.

Medical Social Services

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

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

➢ See *Special Needs Services,* Utilization Management and Medical Management, Chapter G.

Mental Health and Substance Use disorder Benefits

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

Closer Look at Behavioral Health Managed Care Organizations

Providers are required to refer and coordinate a Member's care with Behavioral Health providers

➢ See *UPMC for You (Medical Assistance) Contacts – Table A5*, Welcome and Key Contacts, Chapter A.

Office Visits

PCP visits are covered. Specialist visits are covered with a PCP referral and coordination. Copayments may apply to chiropractor and podiatrist visits for some Members.

➢ See *Copayment Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

Closer Look at Referrals

UPMC *for You* **does not require the submission of paper referral forms.** PCPs may refer a Member to a network specialist following standard medical referral practices such as calling the specialist or by providing the Member a "script" or "letter" for the specialist's records.

The PCP and specialist should coordinate care.

The PCP and specialist must contact **Utilization Management** for prior authorization approval of an out-of-network referral by submitting a request through **Provider OnLine** at **www.upmchealthplan.com/providers**.

Organ Transplants

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

Out-of-Area or Out-of-Network Care

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

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

Medically necessary nonemergency services may be covered if:

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

UPMC *for You* Members are not permitted to self-direct to out-of-network providers except for emergency services or for family planning services; however, providers can request out-of-network care. The provider should contact **Utilization Management** for authorization by submitting a prior authorization request through **Provider OnLine** at **www.upmchealthplan.com/providers**.

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 Member will receive written notification. The provider can appeal a denial by following the instructions outlined in the denial letter.

Alert—Out-of-Network Care Referrals

To send Members to out-of-network specialists or facilities, providers must obtain prior authorization by contacting **Utilization Management** and submitting a prior authorization request through **Provider OnLine** at **www.upmchealthplan.com/providers.** Failure to obtain 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
Utilization 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 of Medicaid funds to institutions or entities located outside of the United States. United States is defined to include the District of Columbia, Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Outpatient Surgery

Medically necessary outpatient surgeries listed on the Medical Assistance fee schedule are covered if performed by a network provider, hospital, or surgical facility. The provider must coordinate care with the Member's PCP and contact **Utilization Management** to obtain authorization for procedures as appropriate. Providers may request prior authorization by logging onto **www.upmchealthplan.com/providers** and entering the authorization request through **Provider OnLine**.

Podiatric Care

Medically necessary podiatric care is covered with a referral from the Member's PCP. Copayments may apply for some Members.

➢ See *Copayment Schedule,* UPMC *for You (*Medical Assistance), Chapter E.

Prescription Drug Coverage

The UPMC *for You* prescription plan features a 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. Members must use the UPMC *for You* pharmacy network. Based on the Member's Medical Assistance category, copayments may apply.

➢ See *UPMC for You Pharmacy Program,* Pharmacy Services, Chapter J.

Closer Look at Prescription Drug Coverage

Providers who have questions about prescriptions should call **Pharmacy Services** at **1-800-396-4139** from 8 a.m. to 5 p.m., Monday through Friday. UPMC *for You* Members 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 Member's PCP and delivered by a network provider. The therapy must be medically necessary and prior authorization must be obtained. The prognosis must indicate the potential for improvement. Copayments for some Members **age 18 and older** may apply.

Outpatient

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

➢ See *Copayment Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

Reproductive Procedures

Abortion

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

An abortion is covered when a physician certifies that due to a condition, illness, or injury, an abortion is necessary to prevent the death of the woman, which is a medical judgment to be made by the certifying physician. A licensed physician may make the certification regardless of whether 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 Member's medical record and a copy submitted with the claim.

Closer Look at Cases of Rape and Incest

In cases of rape or incest, the Member must complete and sign a **Recipient Statement Form (MA-368)** before the abortion (the statement does not have to be notarized). The provider must submit a copy of the statement along with the claim. The statement must note that the Member:

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

The reporting requirement is waived if the Member was the victim of rape or incest but, in the physician's medical judgment, was physically or psychologically incapable of reporting the crime. The physician must give the reasons for the waiver on the Physician Certification for Abortion Form and must obtain a signed statement from the woman indicating she was a victim of rape or incest and that she did not report the crime. A Recipient Statement Form is not needed for abortions necessitated by life-threatening conditions, illnesses, or injuries.

Hysterectomy

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

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

Tubal Ligation

A tubal ligation is covered when coordinated through a PCP or ob-gyn provider and performed by a network provider. The Member must voluntarily give informed consent to the procedure. The Member also must be **at least 21 years old** at the time she gives informed consent and must sign a **Sterilization Consent form (MA-31 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 Member's medical record and a copy of the form must be submitted with the claim.

Vasectomy

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

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

Skilled Nursing Facility Care

Skilled nursing facility care is covered if the treating provider obtains prior authorization, and the care is medically necessary and provided in a licensed facility.

Closer Look at Skilled Nursing Care

A Member who enters a licensed skilled nursing facility will remain the responsibility of UPMC *for You* for up **to 30 consecutive days** (including bed-hold days). **After 30 days**, the Member will be disenrolled from UPMC *for You* and returned to the Medical Assistance fee-for-service program. Continuity of care and transfer of medical records must be ensured during the transition. Upon discharge from the nursing facility the Member will be re-enrolled in UPMC *for You*, (unless they are no longer eligible for medical assistance or they choose a new managed care organization).

Specialist Care

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

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

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

Therapy

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

➢ See *Copayment Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

Urgent Care

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

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

Closer Look at Urgent Care

If the Member is unable to call the PCP before going to the emergency department and the Member does not have an emergency medical condition, the emergency department should attempt to contact the PCP for approval before providing services. If the PCP does not respond **within 30 minutes** or cannot be reached, the emergency department or Member should attempt to contact **Provider Services** at **1-866-918-1595.** If the emergency department cannot reach UPMC *for You,* it should provide the service and attempt to contact the PCP or UPMC *for You* afterward.

Routine Vision Benefits

Routine Vision benefits are provided by **Envolve Vision**. Benefit coverage may vary. Providers and Members may call **Envolve Vision, Inc.** directly at **1-866-458-2138.**

Members 21 years old and older 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 Member chooses standard eyeglasses or contact lenses that are within the allowance, there is no cost to the Member. If the cost exceeds the allowance, the Member will be responsible for any cost over the $100.)
- Glasses or contact lenses to treat cataracts or aphakia (medical condition).
- Specialist eye exam with referral from PCP.

Members younger than 21 years old receive:

- Routine vision exams **twice a year**, or more often if medically necessary.
- A $100 allowance towards eyeglasses or toward one pair of contact lenses and fitting. If the Member chooses standard eyeglasses or contact lenses that are within the allowance, there is no cost to the Member. If the cost exceeds the allowance, the Member will be responsible for any cost over the $100.
- Two frames and four lenses **per year** (from prior service date). (**NOTE**: The second pair of glasses is available if medically necessary. Example: The Member's prescription changes.) Exception to limits can be made if medically necessary and written documentation is provided.
- Replacement of eyeglasses or contact lenses if they are broken or lost, or if there is a prescription change, provided written documentation of the necessity of the service is submitted by the provider.
- Eyeglasses and all other vision services deemed medically necessary provided written documentation of the necessity of the service is submitted by the provider.

Women's Health

Routine Ob-gyn Services

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

Nonroutine Ob-gyn Services

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

Closer Look at Women's Health Services

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

Family Planning

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

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

Pregnancy Care

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

UPMC *for You* enrolls pregnant Members in the UPMC Health Plan Maternity Program, which assesses pregnancy risks and offers Members 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 Members' questions and offer support and advice between their visits.

Maternity program enrollees who are engaged in prenatal care should be encouraged to enroll in the UPMC *for You* Baby Gift Incentive initiative. This program is used to encourage participation in ongoing care and addresses safe travel for the baby. Enrollees who meet the following criteria may be eligible to receive an infant care seat, stroller, or a portable play yard:

- Prenatal care prior to **13 weeks**
- Enrollment in the UPMC Health Plan Maternity Program
- Compliance with lab testing as recommended by provider
- Compliance with all prenatal care visits
- Participation in all scheduled contacts by maternity program staff
- Return a signed consent form for the incentive
- Return a "Baby Gift Checklist" completed by the provider

Providers will need to sign off on the "Baby Gift Checklist" for the Member to verify that the Member attended all appointments and completed recommended lab testing.

Members or providers may call the **UPMC Health Plan Maternity Program** at **1-866-778-6073**, Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

**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 Member's physical, psychological, and emotional history. This information will be used to identify Members at risk for complications in pregnancy and who would benefit from enrollment in the maternity program.

Closer Look at 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 Members 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*, Utilization Management and Medical Management, Chapter G.
- See *Other Resources and Forms*, UPMC *for You* (Medical Assistance), Chapter E.

Other Services

Other services available to UPMC *for You* Members include:

Health Management Programs

UPMC *for You* offers several health management programs, including asthma, cardiovascular disease (coronary artery disease and congestive heart failure), chronic obstructive pulmonary disease, and diabetes at no cost to the Member. Health coaches are available to answer Members' questions and offer support and advice between their visits. Information about the programs is available at **1-866-778-6073** from 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 *for You*'s efforts to improve Members' health by providing intensive case management for Members with specific chronic illnesses.

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

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

In addition, these programs provide help for Members to manage their chronic illnesses through preventive practices and adherence to their treatment plans. Health management programs also help form connections with community support groups and agencies. There are also programs to assist with lifestyle risk goals such as smoking cessation, weight management, nutrition, stress management, and physical exercise. Members enrolled in these programs receive educational materials and have frequent clinical sessions with their health coach.

Providers who serve Members 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 a.m. 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 MyHealth 24/7 Nurse Line

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

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

If a Member, upon enrolling in UPMC *for You*, is receiving services authorized by another 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 Member is **younger or older than 21 years old** and/or the Member is pregnant. However, the provider still must notify UPMC *for You* with information regarding those services. Contact **Utilization Management** at **1-800-425-7800.**

Members younger than 21 years old:

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

Members 21 years old and older:

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

For Members who are pregnant:

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

Before authorization from the previous PH-MCO or fee-for-service program expires, review prior authorization and referral requirements for service and make necessary requests.

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

Services Not Covered

The following services are not covered under the UPMC *for You* program unless pre-approved (prior authorized) by **Utilization Management.** Contact Utilization Management by submitting a request through **Provider OnLine** at **www.upmchealthplan.com/providers** to determine if a service is eligible to be considered for a prior authorization:

- Acupuncture
- Behavioral Health services covered by a Member's Behavioral Health Managed Care Organization (BH-MCO)
- Experimental or investigative treatments
- Home and vehicle modifications
- Infertility services
- Medical services or surgical procedures and diagnostic tests performed on an inpatient basis that could have been performed in the provider's office, the clinic, the emergency department, or a short procedure unit without endangering the life or health of the Member
- Nonmedically necessary treatments or surgery (e.g., cosmetic surgery)
- Out-of-network care, except for emergency services and family planning
  - **NOTE**: Services provided outside of the United States are never covered.
- Procedures or services not on the Medical Assistance fee schedule
- Self-directed care, except as noted in the Coordinated Care section
  - See *Coordinated Care,* UPMC *for You (*Medical Assistance), Chapter E.

Program Exception Process

The program exception process occurs when a provider requests Utilization Management review of a service which is included in the Member's benefit package but is not currently listed on the MA Program fee schedule 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 Member who has exhausted the benefit limit (i.e., duration or quantity) of a particular service.

The Utilization Management Department will consider requests by providers for program exceptions and benefit limit exceptions for UPMC *for You* Members.

Providers may submit exception requests for benefit limit to **Utilization Management** by submitting a request through **Provider OnLine** at **www.upmchealthplan.com/providers** , or sending a letter to:

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

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

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

The provider may request a benefit limit exception before or after the service has been delivered. A Member may only request a benefit limit exception before the service is delivered.

To request a program exception for a UPMC *for You* Member, the provider should submit a request to Utilization Management and offer supporting information demonstrating the medical necessity of the exception. When a Member initiates a request, a Utilization 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.

For an exception request made before the service has been delivered, UPMC *for You* will respond within **21 days** upon receipt of the request. If the provider indicates an urgent need for a quick response, UPMC *for You* will respond within **48 hours** upon receipt of the request. For an exception request after the service has been delivered, UPMC *for You* will respond within **30 days** upon receipt of the request.

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

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

A provider may not hold the Member liable for payment and bill the Member for services that exceed the limits unless the following conditions are met:

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

Closer Look at the Difference Between the Turnaround Times for a Program Exception Request and a Prior Authorization Request.

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

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

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

Closer Look at Benefit Limit Exceptions

Benefit Limit Exception:

An exception to service limits may be granted if the UPMC *for You* Member:

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

Dental Benefit Limit Exception:

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

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

The EPSDT Program

At a Glance

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

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

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

Provider Responsibilities in the EPSDT Program

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

- Provide primary and preventive care to eligible UPMC *for You* Members.
- Act as a Member advocate by providing, recommending, and arranging for medically necessary care.
- Maintain the continuity of care for each Member in his or her care.
- Coordinate the Member's physical and behavioral health care needs.
- Provide referrals for any medical services that cannot be provided by the PCP, including referrals for network specialists and obtaining authorization for out-of-network care.
- Refer the Member to a dental home **by age 1** and notify the Special Needs Department of the referral utilizing the appropriate dental fax form.
- Locate, coordinate, and monitor all primary care and other medical and rehabilitative services for Members.
- Perform and report all EPSDT screens in the appropriate format, including all applicable procedure codes and modifiers.
- Provide childhood lead poisoning prevention services in accordance with DHS's EPSDT program requirements and lead screening guidelines established by the Centers for Disease Control and Prevention (CDC).
- Coordinate and monitor the care provided to Members by other health care practitioners.

- Maintain a centralized and current medical record, including documentation of all services provided as well as referrals to specialists. Include a copy of the completed validated developmental or autism screening tools used.

- In cases of suspected developmental delay or elevated blood lead levels, the PCP must contact **CONNECT** at **1-800-692-7288** to refer the child for early intervention services, or via UPMC Health Plan website – Provider, EPSDT Clinical and Operational Guidelines, Dental and CONNECT Referral form. The referral must be documented in the medical record. Providers may contact the **UPMC Health Plan Special Needs Unit** at **1-866-864-1462** to discuss next steps for **children 0-5 years old.**

- Arrange all medically necessary follow-up care.

- Arrange case management services for Members with complex medical needs, including serious multiple disabilities or illnesses.

- If necessary, provide the Member's parent (or guardian) with information on how to access mental health services, or inform the appropriate county children and youth agency in cases of neglect or abuse.

- Contact Members who are not compliant with the EPSDT periodicity and immunization schedule, as indicated on the UPMC *for You* EPSDT quarterly roster. PCPs should contact Members **within one month** of the noncompliance to schedule an appointment. PCPs also should document the reason for noncompliance and that efforts have been made to bring Members into compliance. Members who are noncompliant may be referred to a **health coach** by contacting the **EPSDT Department** at **1-866-463-1462.**

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

  - See *Preventive Pediatric Oral Health Care Periodicity Recommendations*, UPMC *for You (*Medical Assistance), Chapter E.

Closer Look at the Quarterly EPSDT Roster

An EPSDT roster is sent quarterly to any provider who has a UPMC *for You* Member **younger than 21 years old**. This roster contains information on Members who are due and overdue for an EPSDT screening.

If a provider is not utilizing the rosters to determine needed outreach and has opted to suppress the receipt of the rosters, an alternative process must be put in place to contact Members that are due or overdue for their screenings.

EPSDT Appointment Scheduling and Outreach

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

- Contact new Members to explain the EPSDT program.
- Emphasize the importance of well-child preventive care and immunizations to all Members.
- Assist the Member in scheduling an appointment with the PCP.
- Assist in scheduling appointments for existing Members who are due for a screening.
- Assist in scheduling a new Member exam within **45 days** of enrollment with UPMC *for You*, according to the periodicity schedule, unless the child is already under the care of a PCP and is current with screens and immunizations.

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

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

EPSDT Services

Under Pennsylvania and federal laws, the EPSDT program must provide the following services according to a periodicity schedule developed by DHS as recommended by the American Academy of Pediatrics. A complete listing of services, schedule, guidelines and other information can be found on the UPMC Health Plan web site and within Medical Assistance Bulletins.

➢ See *Other Resources and Forms,* UPMC *for You* (Medical Assistance), Chapter E

Services:

- Screening services, including a comprehensive health and developmental history, developmental assessment, nutritional assessment, and all appropriate immunizations
- An unclothed comprehensive physical examination
- Calculation of body mass index
- Health education and guidance: Age appropriate nutritional counseling, anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate laboratory tests, including hemoglobin and hematocrit, urinalysis, iron levels, TB skin testing, sickle cell anemia screening, and lead levels (by the child's **first birthday** or as appropriate and consistent with the current CDC standard).
- Newborn metabolic/hemoglobin screening and follow-up: newborn bilirubin screening, growth measurements and head circumference

- Psychosocial/behavioral assessments: Mental health services, including counseling. Assessment should be family centered and may include an assessment of the child's social-emotional health, caregiver depression, and social determinants of health
- Maternal depression screening: Administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
- Referral to behavioral health or medical providers to correct or ameliorate any problems discovered upon the screen, including those not covered on the Medical Assistance fee-for-service program
- Teenage pregnancy services or referral for those services
- Drug and alcohol use assessment
- Screening for sexually transmitted infections (STI) for sexually active individuals
- Testing for HIV and annual reassessment, for those at increased risk for HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs
- Vision services, including diagnosis and treatment for defects in vision, and eye exams for the provision of glasses. Screening for visual acuity using traditional methods (e.g. Snellen chart) or instrument-based screening for visual acuity and other ocular risk factors. Instrument-based screening may be completed to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional screening.
- Hearing services, including diagnosis and treatment for defects in hearing, and testing or the provision of hearing aids. Newborns should receive a hearing screening prior to their discharge from the hospital. A hearing screening is to be performed during the newborn screening and if not, must be completed **by age 3 months**.
- Ordering of all other medically necessary health care, diagnostic services, and treatment measures
- Dental screening, including diagnosis and treatment of dental disease, no later than age 1. PCPs should conduct an oral exam as part of the comprehensive examination. Administration of oral health risk assessment and assessment of the need for fluoride supplementation. Determination of whether the individual has a dental home or if a referral is needed.

  ➢ See *Preventive Pediatric Oral Health Care Periodicity Recommendations,* UPMC *for You (*Medical Assistance), Chapter E.

- Autism screening utilizing a standard screening tool
    - ➢ See *Validated Screening Tools Chart*, UPMC *for You (*Medical Assistance), Chapter E.
- Developmental screening utilizing a standard screening tool
    - ➢ See *Validated Screening Tools Chart*, UPMC *for You (*Medical Assistance), Chapter E.
    - ➢ See *EPSDT Periodicity Schedule*, UPMC *for You (*Medical Assistance), Chapter E.

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

Initial EPSDT Visits for Newborns

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

The first follow-up visit for the newborn should be provided within **three to five days** after discharge from the hospital. The exact timeframe for this visit varies based on method of delivery, maternal or neonatal complications, and resulting length of stay in the hospital.

Diagnosis and Treatment in the EPSDT Program

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

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

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

At the first appointment following enrollment of a Supplemental Security Income (SSI) Member or SSI-related Member (i.e., spouse and dependents), the PCP should conduct a complete assessment to determine the child's health care needs over an appropriate period (**not to exceed one year**).

The initial appointment should occur within **45 days** of enrollment with UPMC *for You*, unless the Member already is receiving care with a PCP or specialist.

The assessment should include the child's need for specialty care, which will be discussed with the caregiver, custodial agency and, when age-appropriate, the child. This assessment becomes part of the child's medical record.

The PCP, at the time of the initial exam, must make a recommendation regarding case management services. With the caregiver's or custodial agency's consent, the PCP should contact **Special Needs** at **1-866-463-1462** with a referral for case management services.

Childhood Lead Poisoning Prevention

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

PCPs should conduct blood lead testing or refer the testing to a participating laboratory in accordance with the EPSDT Periodicity Schedule. Children with elevated lead levels should be identified on the CMS-1500 claim form utilizing the appropriate diagnosis code and EPSDT modifiers.

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

Alert—High Lead Levels

PCPs who discover patients **younger than 21 years old** with blood lead levels equal to or **greater than 5µg /dL** must contact **CONNECT** at **1-800-692-7288** and also are requested to contact the **Special Needs Department** at **1-866-463-1462** for monitoring. The referral to **CONNECT** must be documented in the medical records. Children with elevated lead levels should be managed according to CDC recommendations.

Environmental Lead Investigations

Environmental Lead Investigation is completed in accordance with the PA Department of Health recommendations. UPMC *for You* contracts with Environments Lead Investigators who possess current certification from the Pennsylvania Department of Labor and Industry as an environmental risk assessor or a lead inspector.

EPSDT Expanded Services

Expanded services are those required to treat conditions a provider detects during an encounter with a Member that may or may not normally be covered by the Medical Assistance program. UPMC *for You* Members **younger than 21 years old** are eligible for medically necessary expanded services.

All requests for EPSDT expanded services should be forwarded to the **Utilization Management Department** to obtain a prior authorization by submitting a request through **Provider OnLine** at **www.upmchealthplan.com.providers**. The request must include a letter of medical necessity describing the rationale for the expanded services and the benefit the service will provide the Member. Utilization Management will review the prior authorization request for medical necessity with the medical director. Urgent requests are processed within **24 hours** to ensure that the child's medical care is not jeopardized.

The Member and provider will be notified of the decision regarding the request for service within **21 days** of the receipt of the request. This notice includes denials, reductions, or changes in scope or duration of services. If the decision to approve or deny a covered service or item is not made **by the 21st day** from the date the request was received, the service or item is automatically approved.

➢ See *Services Requiring Prior Authorization*, Utilization Management and Medical Management, Chapter G.

EPSDT Data Collection and Follow-up

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

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

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

UPMC *for You*
PO Box 2995
Pittsburgh, PA 15230-2995

School-based and School-linked Services

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

- Make sure PCPs interact with school-based centers as necessary.
- Arrange for the coordination and integration of school-based health service information into the PCP's Member record, as necessary.
- Help coordinate specialized treatment plans for children with special health care needs, including participation on interagency teams.

Member Complaint and Grievance Procedures

Closer Look at How a Member Files a Complaint or Grievance.

UPMC *for You* Members have a complaint, grievance, and fair hearing process available to them if they are unhappy about services provided by UPMC *for You* or their provider.

The Member 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.

The following are instructions that have been provided to the Member in their UPMC *for You* Member handbook on how they may file a complaint, grievance, request a fair hearing, an external grievance review, and how to continue to receive services during the process.

The UPMC *for You* Member complaint, grievance and fair hearing process is separate and distinct from the Provider Dispute process outlined in the UPMC Health Plan provider manual, Chapter B, Provider Standards and Procedures.

Complaints, Grievances, and Fair Hearings

If a provider or UPMC *for You* does something that you are unhappy about or do not agree with, you can tell UPMC *for You* or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UPMC *for You* has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell UPMC *for You* you are unhappy with UPMC *for You* or your provider or do not agree with a decision by UPMC *for You*.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that UPMC *for You* has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call UPMC *for You* at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Complaint, or
- Write down your Complaint and send it to UPMC *for You* by mail or fax, or
- If you received a notice from UPMC *for You* telling you UPMC *for You*'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to UPMC *for You* by mail or fax.

UPMC *for You*'s address and fax number for Complaints:

UPMC *for You*
Complaints, Grievances, and Appeals
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- UPMC *for You* has decided that you cannot get a service or item you want because it is not a covered service or item.
- UPMC *for You* will not pay a provider for a service or item you got.
- UPMC *for You* did not tell you its decision about a Complaint or Grievance you told UPMC *for You* about within **thirty days** from when UPMC *for You* got your Complaint or Grievance.
- UPMC *for You* has denied your request to disagree with UPMC *for You*'s decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

Table E2: Appointment Standards

New Member appointment for Your first examination…	We will make an appointment for You…
Members with HIV/AIDS	with PCP or specialist no later than **7 days** after you become a Member in UPMC *for You* unless you are already being treated by a PCP or specialist.
Members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than **45 days** after you become a Member in UPMC *for You*, unless you are already being treated by a PCP or specialist.
Members under the age of 21	with PCP for an EPSDT exam no later than **45 days** after you become a Member in UPMC *for You***,** unless you are already being treated by a PCP or specialist.
all other Members	with PCP no later than **3 weeks** after you become a Member in UPMC *for You*

Members who are pregnant:	We will make an appointment for you . . .
pregnant women in their first trimester	with OB/GYN provider within **10 business days** of UPMC *for You* learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within **5 business days** of UPMC *for You* learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within **4 business days** of UPMC *for You* learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within **24 hours** of UPMC *for You* learning you are pregnant

Appointment with…	An appointment must be scheduled . . .
PCP	
urgent medical condition	Within **24 hours**
routine appointment	within **10 business days**.
health assessment/general physical examination	within **3 weeks**.

Specialists (when referred by PCP)	
urgent medical condition	within **24 hours** of referral.
routine appointment with one of the following specialists: • Dentist • Dermatology • Orthopedic Surgery • Otolaryngology • Pediatric Allergy & Immunology • Pediatric Endocrinology • Pediatric Gastroenterology • Pediatric General Surgery • Pediatric Hematology • Pediatric Infectious Disease • Pediatric Nephrology • Pediatric Neurology • Pediatric Oncology • Pediatric Pulmonology • Pediatric Rehab Medicine • Pediatric Rheumatology • Pediatric Urology • Pediatric Dentistry	within **15 business days** of referral
routine appointment with all other specialists	within **10 business days** of referral

You may file all other Complaints at any time.

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Complaint, and about the First Level Complaint review process.

You may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UPMC *for You*.

You may attend the Complaint review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Complaint review at least **10 days** before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of **1 or more** UPMC *for You* staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. UPMC *for You* will mail you a notice within **30 days** from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within **10 days** of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like UPMC *for You*'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- UPMC *for You*'s decision that you cannot get a service or item you want because it is not a covered service or item
- UPMC *for You*'s decision to not pay a provider for a service or item you got
- UPMC *for You*'s failure to decide a Complaint or Grievance you told UPMC *for You* about within **30 days** from when UPMC *for You* got your Complaint or Grievance
- You not getting a service or item within the time by which you should have received it
- UPMC *for You*'s decision to deny your request to disagree with UPMC *for You*'s decision that you have to pay your provider

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call UPMC *for You* at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Second Level Complaint, or
- Write down your Second Level Complaint and send it to UPMC *for You* by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to UPMC *for You* by mail or fax.

UPMC *for You*'s address and fax number for Second Level Complaints

UPMC *for You*
Complaints, Grievances, and Appeals
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Complaint, and about the Second Level Complaint review process.

You may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UPMC *for You*.

You may attend the Complaint review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Complaint review at least **15 days** before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of **3 or more people**, including at least **1 person** who does not work for UPMC *for You*, will meet to decide your Second Level Complaint. The UPMC *for You* staff on the committee will not have been involved in and will not have worked for someone who was

involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee.

UPMC *for You* will mail you a notice within **45 days** from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

What if I Do Not Like UPMC *for You*'s Decision on My Second Level Complaint?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

You must send your request for external review of your Complaint in writing to either:

Pennsylvania Department of Health **Bureau of Managed Care** **Health and Welfare Building, Room 912** **625 Forster Street** **Harrisburg, PA 17120-0701** **Telephone Number: 1-888-466-2787**	**or**	**Pennsylvania Insurance Department** **Bureau of Consumer Services** **Room 1209, Strawberry Square** **Harrisburg, Pennsylvania 17120** **Telephone Number: 1-877-881-6388**

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The Insurance Department reviews Complaints that involve UPMC *for You*'s policies and procedures. If you send your request for external review to the wrong Department, it will be sent to the correct Department.

What Happens After I Ask for an External Complaint Review?

The Department of Health or the Insurance Department will get your file from UPMC *for You*. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Compliant review is postmarked or hand-delivered within **10 days** of the date on the notice telling you UPMC *for You's* First Level Complaint decision that you cannot get service or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made.

GRIEVANCES

What is a Grievance?

When UPMC *for You* denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you UPMC *for You*'s decision.

A Grievance is when you tell UPMC *for You* you disagree with UPMC *for You*'s decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call UPMC *for You* at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or
- Write down your Grievance and send it to UPMC *for You* by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from UPMC *for You* and send it to UPMC *for You* by mail or fax.

UPMC *for You*'s address and fax number for Grievances:

UPMC *for You*
Complaints, Grievances, and Appeals
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Grievance, and about the Grievance review process.

You may ask UPMC *for You* to see any information that UPMC *for You* used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to UPMC *for You*.

You may attend the Grievance review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Grievance review at least **10 days** before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of **3 or more people**, including a licensed doctor, will meet to decide your Grievance. The UPMC *for You* staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. UPMC *for You* will mail you a notice within **30 days** from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within **10 days** of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like UPMC *for You*'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for UPMC *for You*.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call UPMC *for You* at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or

- Write down your Grievance and send it to UPMC *for You* by mail to

UPMC *for You*
Complaints, Grievances, and Appeals
PO Box 2939
Pittsburgh, PA 15230-2939

UPMC *for You* will send your request for external Grievance review to the Department of Health.

What Happens After I Ask for an External Grievance Review?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

UPMC *for You* will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within **15 days** of filing the request for an external Grievance review.

You will receive a decision letter within **60 days** of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within **10 days** of the date on the notice telling you UPMC *for You's* Grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30 days** to get a decision about your First Level Complaint or Grievance, or **45 days** to get a decision about your Second Level Complaint, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask UPMC *for You* for an early decision by calling UPMC *for You* at **1-800-286-4242 (TTY: 711),** faxing a letter or the Complaint/Grievance Request Form to 412-454-7920, or sending an email to: **upmcforyouappeals@upmc.edu.**

- Your doctor or dentist should fax a signed letter to **412-454-7920** within **72 hours** of your request for an early decision that explains why UPMC *for You* taking **30 days** to tell you a decision about your First Level Complaint or Grievance, or **45 days** to tell you a decision about your Second Level Complaint, could harm your health.

If UPMC *for You* does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, UPMC *for You* will decide your Complaint or Grievance in the usual time frame of **30 days** from when UPMC *for You* first got your First Level Complaint or Grievance, or **45 days** from when UPMC *for You* got your Second Level Complaint.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because UPMC *for You* has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

UPMC *for You* will tell you the decision about your Complaint within **48 hours** of when UPMC *for You* gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within **72 hours** from when UPMC *for You* gets your request for an early decision, whichever is sooner, unless you ask UPMC *for You* to take more time to decide your Complaint. You can ask UPMC *for You* to take up to **14 more days** to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within **2 business days from the date you get the expedited Complaint decision notic**e. To ask for expedited external review of a Complaint:

- Call UPMC *for You* at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Complaint, or
- Send an email to UPMC *for You* at **upmcforyouappeals@upmc.edu,** or
- Write down your Complaint and send it to UPMC *for You* by mail or fax:

UPMC *for You*
Complaints and Grievances Department
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

Expedited Grievance and Expedited External Grievance

A committee of **3 or more people**, including a licensed doctor, will meet to decide your Grievance. The UPMC *for You* staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because UPMC *for You* has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

UPMC *for You* will tell you the decision about your Grievance within **48 hours** of when UPMC *for You* gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within **72 hours** from when UPMC *for You* gets your request for an early decision, whichever is sooner, unless you ask UPMC *for You* to take more time to decide your Grievance. You can ask UPMC *for You* to take **up to 14 more days** to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call UPMC *for You* **at 1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or
- Send an email to UPMC *for You* at **upmcforyouappeals@upmc.edu**, or
- Write down your Grievance and send it to UPMC *for You* by mail or fax:

UPMC *for You*
Complaints and Grievances Department
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

UPMC *for You* will send your request to the Department of Health within **24 hours** after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff Member of UPMC *for You* will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff Member. This staff Member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family Member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell UPMC *for You*, in writing, the name of that person and how UPMC *for You* can reach him or her.

You or the person you choose to represent you may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call UPMC *for You* toll-free telephone number at **1-800-286-4242 (TTY: 711)** if you need help or have questions about Complaints and Grievances, you can contact your local **Legal Aid office** at **1-800-322-7572** or call the **Pennsylvania Health Law Project** at **1-800-274-3258.**

Persons Whose Primary Language Is Not English

If you ask for language services, UPMC *for You* will provide the services at no cost to you.

Persons with Disabilities

UPMC *for You* will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by UPMC *for You* at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases, you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something UPMC *for You* did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after UPMC *for You* decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you UPMC *for You*'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- UPMC *for You*'s failure to decide a First Level Complaint or Grievance you told UPMC *for You* about within **30 days** from when UPMC *for You* got your Complaint or Grievance.
- The denial of your request to disagree with UPMC *for You*'s decision that you have to pay your provider.

- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within **120 days** from the date on the notice telling you that UPMC *for You* failed to decide a First Level Complaint or Grievance you told UPMC *for You* about within **30 days** from when UPMC *for You* got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the Member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least **10 days** before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family Member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

UPMC *for You* will also go to your Fair Hearing to explain why UPMC *for You* made the decision or explain what happened.

You may ask UPMC *for You* to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within **90 days** from when you filed your Complaint or Grievance with UPMC *for You*, not including the number of days between the date on the written notice of the UPMC *for You*'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because UPMC *for You* did not tell you its decision about a Complaint or Grievance you told UPMC *for You* about within **30 days** from when UPMC *for You* got your Complaint or Grievance, your Fair Hearing will be decided within **90 days** from when you filed your Complaint or Grievance with UPMC *for You*, not including the number of days between the date on the notice telling you that UPMC *for You* failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision. If you Fair Hearing is not decided within **90 days** from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at **1-800-798-2339** to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within **10 days** of the date on the notice telling you UPMC for *You's* First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at **1-800-798-2339** or by faxing a letter or the Fair Hearing Request Form **to 717-772-6328.**

Your doctor or dentist must fax a signed letter to **717-772-6328** explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within **3 business days** after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call UPMC *for You's* toll-free telephone number at **1-800-322-7572** if you need help or have question about Fair Hearings, you can contact your local legal aid office at **1-800-274-3258** or call the Pennsylvania Health Law Project at **1-800-274-3258.**

Other Resources and Forms

www.upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx

- Childhood Nutrition and Weight Management Services
- Dental and Connect Referral form
- Preventive Pediatric Oral Health Care Periodicity Recommendations, (Dental Periodicity Schedule)
- Developmental Delays or Autism Spectrum Disorders Screening Forms
- EPSDT billing guide
- EPSDT CMS-1500 claim form – sample
- EPSDT Periodicity Coding Matrix
- EPSDT Periodicity Schedule
- EPSDT Periodicity schedule – day calculator
- EPSDT quarterly report – sample
- Immunization schedule (**0-6 years**)
- Immunization schedule (**7-18 years**)

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 prior authorization and referral requirements.

Copayment Schedule

Table E3: Copayments Schedule

Adult Medical Assistance - Members Ages 18 and older	
Services	**Copay**
Ambulance (per trip)	$0
Dental Care	$0
Inpatient Hospital (Acute or Rehab)	
Per Day	$3
Maximum with Limits	$21
Medical Centers	
Emergency Department (nonemergent visits)	$1-3
Ambulatory Surgical Center	$3
Federal Qualified Health Center or Regional Health Center	$0
Independent Medical/Surgical Center	$2
Convenience Care or Urgent Care Centers	$2
Short procedure unit	$3
Medical Equipment	
Purchase	$0
Rental	$0
Medical Visits	
Certified nurse practitioner	$0
Chiropractor	$1-3
Doctor (PCP- ob-gyn)	$0
Optometrist	$0
Podiatrist	$1-3
Therapy, (Occupational, Physical, Speech)	$1-3
Outpatient Hospital (includes Hospital Based Clinics)	
Per Visit	$2
Prescriptions	
Generic	$1
Brand	$3
Diagnostic Services (not performed in a doctor's office)	
Medical diagnostic testing (per service)	$1
Radiology diagnostic testing (per service)	$1
Nuclear Medicine (per service)	$1
Radiation Therapy (per service)	$1

