UPMC Health Plan
Medicare Special Needs Plans

At a Glance

UPMC *for Life* Dual (HMO SNP)

UPMC *for Life* Dual is a Medicare Special Needs Plan that provides medical and prescription drug benefits for beneficiaries eligible for both Medicare Parts A and B and full Medical Assistance. UPMC *for Life* Dual offers enhanced dental, vision, hearing, transportation, meals, bathroom safety devices, an over-the-counter benefit, personal emergency response systems, and fitness benefits for dual eligible beneficiaries, along with extra benefits and services that help members manage their overall health and wellness. UPMC *for Life* Dual can also help coordinate Medicare and Medical Assistance services.

Beginning in 2020, there are two UPMC *for Life* Dual Plans.

- Under CMS **Contract H4279,** the member must reside in one of the following counties:
  - Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler,
  - Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Crawford,
  - Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene,
  - Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence,
  - Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe,
  - Montour, Northampton, Perry, Pike, Potter, Schuylkill, Snyder, Somerset,
  - Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne,
  - Westmoreland, Wyoming, and York.

- Under CMS **Contract H7123**, the member must reside in one of the following counties:
  - Bucks, Chester, Delaware, Montgomery, and Philadelphia.

  ➢ **NOTE**: The enhanced benefits offered in these two plans have differing amounts.

PCP Selections for Both Plan Choices

All plan members must select a primary care provider, or PCP, to receive coverage. If a PCP is not selected, the UPMC Special Needs Plan Health Care Concierge team will contact the member to assist with PCP selection. All services, whether coordinated through a PCP or self-directed, must be performed by a UPMC Medicare Special Needs Plan provider. UPMC Medicare Special Needs Plans allow members to see participating specialists without a referral from their PCP. Women may self-direct care to ob-gyns for routine annual exams.

Closer Look at Self-Directed Care

Nonemergency, self-directed care performed by out-of-network specialists is not covered unless prior authorization is obtained from **Utilization Management.** Providers must contact Utilization Management by submitting a request for prior authorization through Provider OnLine at **www.upmchealthplan.com/providers** or by calling **1-800-425-7800** from 8 a.m. to 4:30 pm, Monday through Friday.

This chapter contains information providers need to deliver care to members enrolled in UPMC Medicare Special Needs Plans. Plan benefits change annually. Providers need to go to **www.upmchealthplan.com/snp** to get the most current information regarding a specific member's benefits or to address other issues not covered in this manual.

Providers should verify member eligibility before they perform a service. Providers may verify member information through Provider OnLine at **www.upmchealthplan.com.** Or they may call UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

- See ***Identifying Members and Verifying Eligibility***, Member Administration Chapter I.

Closer Look at Restrictions on Member Cost-Sharing and Balance Billing

Balance Billing Guidelines

The annual deductible, coinsurance, and copayments may apply to plan services. Providers may submit any unpaid balance remaining, after UPMC Health Plan payments, to the appropriate State source for consideration.

However, providers **may not** attempt to collect copayments (other than permitted Medical Assistance copayments), deductibles, or coinsurance from members enrolled in UPMC *for Life* Dual for any services provided during the member's enrollment in UPMC *for Life* Dual, including the period of time in which a member has lost full Medical Assistance coverage but is deemed "continued eligible" for the "Grace Period" of up to **180 days**.

- **NOTE**: This includes services provided during the "Grace Period."

Attempting to collect the deductible, coinsurance, or copayments from members will hereafter be referred to as ***balance billing***. Federal law prohibits Medicare providers from balance billing a Qualified Medicare Beneficiary (QMB) under any circumstances.

- **NOTE:** See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997.

Closer Look at the Grace Period

A grace period is a length of time following the loss of special needs status, by a member, during which the plan continues to pay for covered services.

For UPMC *for Life* Dual, the grace period begins when a member loses his or her special needs status (e.g., through loss of Medical Assistance eligibility) and continues for a period of up to **180 days**.

During this time, all restrictions on member cost-sharing and balance billing guidelines continue to apply. If a member does not regain his or her special needs status by the end of the grace period, he or she will be disenrolled from the UPMC Medicare Special Needs Plan.

Key Points

- A PCP is mandatory.
- Network providers and facilities must be used.
- Certain routine preventive care services are covered. A list of preventive services can be found in the Preventive Services section.
  - See ***Preventive Services***, UPMC Medicare Special Needs Plans, Chapter M.
- Emergency care by any provider is covered if the member believes that his or her health is in serious danger.
- Urgent care is covered if the member believes that, if left untreated, his or her condition could rapidly become a medical emergency. Out-of-area urgent care is covered without prior authorization. Urgent care received within the service area must be performed by a network provider.
- Out-of-area dialysis does not require prior authorization.
- Inpatient hospital care requires an authorization before admission, except in an emergency.
- Members have a lifetime limit of **190 days** in a freestanding psychiatric hospital.

- Outpatient mental health and substance use disorder services are a covered benefit.
- Office visits to physicians, specialists, nurse practitioners, physician assistants, chiropractors, podiatrists, or other participating health care professionals are covered for UPMC Medicare Special Needs Plan members.
- Outpatient rehabilitation therapy includes physical therapy, speech and language therapy, occupational therapy, and cardiac/pulmonary therapy.
- Medicare-covered outpatient surgical procedures performed at an ambulatory surgical center, an outpatient hospital facility, or the physician's office are covered.
- UPMC Medicare Special Needs Plan members are covered for certain podiatry services, such as treatment of injuries and diseases of the feet (e.g., hammertoe or heel spurs).
- UPMC Medicare Special Needs Plan members receive comprehensive dental benefits, which include fillings and simple tooth extractions, dentures, bridges, crowns, and root canals.

Covered Benefits and Services

UPMC Medicare Special Needs Plan members receive all the benefits offered by Original Medicare as well as additional benefits. Plan members must use providers that participate in the UPMC Medicare Special Needs Plan networks.

- **NOTE**: Some benefits and services require authorization.

According to CMS guidelines, Medicare patients must be given proper advance notice on whether a service or treatment is covered or not.

Importantly, if proper notice is not given, the patient will not be required to pay for the service except for applicable cost-sharing (copay/coinsurance). In some cases, UPMC Health Plan may not be liable for payment either, which would place responsibility for payment on the provider.

The following is a review of the advance notice process:

- For a patient with **Original Medicare**, an **Advance Beneficiary Notice (ABN)** is considered valid advance notice that a service is not or may not be covered.
- For a patient with a **Medicare Advantage plan**, such as UPMC *for Life*, an ABN **is not** considered a valid advance notice that a service is not or may not be covered, and therefore, should **not** be used for UPMC *for Life* members.
- For a patient with a **Medicare Advantage plan** such as UPMC *for Life*, the **Notice of Denial of Medical Coverage (NDMC)—**or what is now called the **Integrated Denial Notice (IDN)—**must be used as the advance notice that a service is not or may not be covered.
  - See ***Integrated Denial Notice***, Chapter M – Appendix A
- The NDMC/IDN must be sent to a Medicare Advantage member when a decision is made in response to a request for authorization for services made to the plan by a member, their authorized representative, or a provider.
- If a provider renders services that are either noncovered services, or services that are covered only through criteria defined by a UPMC Health Plan pay policy, the member must have received an NDMC/IDN in advance of services being rendered or be held harmless from financial responsibility other than applicable cost sharing.
- If a contracted provider renders said services, submits a claim, and the claim is denied, the provider can request a provider dispute.
  - **NOTE:** The provider dispute process is separate and distinct from the Member appeal process.
  - See ***Provider Disputes***, Provider Standards and Procedures, Chapter B.

- If a contracted provider renders said services, submits a claim, the claim is denied, and the member or their authorized representative appeals through the member appeal process, UPMC Health Plan's Complaints and Grievances Department will process the appeal in accordance with the following decision guidelines:

    - If it is demonstrated that the member was provided proper advance notice (NDMC/IDN) prior to services being rendered, the appeal can be upheld, affirming the decision to deny the claim, and the contracted provider would retain the right to bill the member directly for the noncovered services.

    - If the member contract, known as the **Evidence of Coverage (EOC)**, clearly states that the specific service(s) rendered are never covered, the appeal can be upheld, affirming the decision to deny the claim, and the contracted provider would retain the right to bill the member directly for the noncovered services.

    - If the Complaints and Grievances Department can neither verify that proper notice was given, nor establish in the EOC that a service is clearly never covered, Complaints and Grievances will contact the contracted provider and advise that the member be held harmless from financial liability other than applicable cost sharing. The provider will have to write off the charges. Once UPMC Health Plan receives acknowledgement from the provider that the member will not receive further bills for the service(s), the Complaints and Grievances Department will withdraw the member appeal request.

Providers should refer to **www.upmchealthplan.com/snp** for detailed information about the member's specific benefits and possible service limitations.

Ancillary Services

Utilization Management can assist providers with the coordination of complex ancillary services, such as the following by accessing Provider OnLine at **www.upmchealthplan.com/providers.**

- Chiropractic care
- Diagnostic services (e.g., lab, x-ray), including special diagnostics
- Home medical equipment (HME), including custom wheelchairs and rehabilitation equipment
- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides; and registered dietitian services)
- Home infusion therapy
- Hospice care

- Laboratory services
- Non-emergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Respiratory equipment, including oxygen therapy
  - **NOTE:** Copayments or coinsurance may apply.

Chiropractic Care

Manual manipulation of the spine to correct subluxation, which is the chiropractic coverage offered by Original Medicare, is available to all UPMC Medicare Special Needs Plan members.

These chiropractic services do not have to be coordinated by a member's PCP, but they must be performed by network providers.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Dental Services

UPMC Health Plan's routine dental benefit vendor is **Avesis Third Party Administrators, Inc.** UPMC Medicare Special Needs Plan members have coverage for two routine oral exams, two cleanings, and two x-rays every year. In addition, UPMC Medicare Special Needs Plan members receive comprehensive dental benefits that include fillings and simple tooth extractions, bridges, crowns, dentures and root canals. Providers should contact **Avesis** at **1-888-729-7951** for specific benefit information.

Closer Look at Non-Routine Dental Services

Coverage is provided via UPMC Medicare Special Needs Plans (not by Avesis) for Medicare-covered dental procedures along with emergency coverage for accidents or injury to natural teeth. For questions about non-routine dental services, providers may call **Provider Services** at **1-866-918-1595**. Members may call the **UPMC Medicare Special Needs Plan Health Care Concierge team** directly at **1-800-606-8648. (TTY: 711)**

➢ **NOTE:** The Health Care Concierge team's hours of operation change twice a year.

From **October 1 through March 31**	Seven days a week from 8 a.m. to 8 p.m.
From **April 1 through September 30**	Monday through Friday from 8 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.

Diagnostic Services

Diagnostic services include x-rays, laboratory services, and tests. All UPMC Medicare Special Needs Plan members need a prescription to obtain any diagnostic service.

Reminders:

- Use the Radiology Decision Support Tool prior to prescribing high-technology imaging services.
- The preferred provider for laboratory and diagnostic procedures is Quest Diagnostics.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Emergency Department Care

All UPMC Medicare Special Needs Plan members have no copayment for emergency department care. Members should notify their PCP within **24 hours** or as soon as reasonably possible after receiving the emergency service.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Alert—Emergency Care

All members, if they believe that they are experiencing a true medical emergency, may utilize any emergency department or office. Out-of-network care for emergencies, including ambulance services, is covered

Closer Look at Emergency Admission

The hospital or facility must contact **Utilization Management** through Provider OnLine at **www.upmchealthplan.com** within **48 hours** or on the **next business day** after the emergency admission.

Hearing Services

Coverage is provided for Medicare-covered diagnostic hearing exams. Routine hearing exams and a hearing aid allowance is covered under UPMC *for Life* Dual only.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Hospice Care

Coverage for hospice services is provided under Original Medicare when the member elects hospice benefits. The member must have a terminal condition with a **six-month or less** life expectancy and must also waive his or her rights to Part B services for the terminal condition. The designated hospice provider is responsible for the medical treatment for the terminal condition, including pain medications. Services for any other medical conditions, including other prescriptions, are covered by UPMC Medicare Special Needs Plans.

Inpatient Hospital Care

Inpatient hospital care requires authorization before admission, except in an emergency. Providers should contact **Utilization Management** by submitting a prior authorization through Provider OnLine at **www.upmchealthplan.com/providers**. For emergency admission, providers must also contact Utilization Management within **48 hours** or on the **next business day** to authorize admissions.

UPMC Medicare Special Needs Plan members have **90 days** of inpatient coverage per benefit period plus an additional one time **60 lifetime reserve (LTR) days**. There is no deductible, copayment or coinsurance for the initial confinement in a benefit period.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Closer Look at Benefit Periods

A benefit period begins the day the UPMC Medicare Special Needs Plan member is admitted to a hospital or skilled nursing facility and ends when the member has been discharged for at least **60 consecutive days**. If the member is admitted to a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a UPMC Medicare Special Needs Plan member may have.

Medical Nutrition Therapy

Medical nutrition therapy (MNT) is covered for UPMC Medicare Special Needs Plan members who are diagnosed with diabetes or renal disease or who have received a kidney transplant within the **last three years**. Services must be provided by a registered dietitian or nutrition professional. For the **first year**, the available benefit is **three hours** of one-on-one counseling. In **subsequent years**, the available benefit is **two hours** of one-on-one counseling.

UPMC *for Life* Dual members have additional MNT benefits available if the member is diagnosed with cancer, Alzheimer's disease, stroke, or multiple sclerosis.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder services are a covered benefit.
To determine if a service is covered or may require a prior authorization contact **Utilization Management** through Provider OnLine at **www.upmchealthplan.com/providers.**

- See ***UPMC Behavioral Health Services***, Chapter L for complete benefit information.

Orthotics and Prosthetics

A network podiatrist may supply orthotics or prosthetics to UPMC Medicare Special Needs Plan members only if the podiatrist is also contracted as a home medical equipment (HME) provider. If a provider who is not contracted as an HME provider supplies them, UPMC Medicare Special Needs Plans will not reimburse these items, and the member **will not be** responsible for any charges.

Prescription Drug Coverage

All members of UPMC Medicare Special Needs Plans have coverage through Medicare Part D along with limited drug coverage as required by Medicare through Medicare Part B.

Dual eligible UPMC Medicare Special Needs Plan members are deemed eligible for the **Low-Income Subsidy (LIS)** prescription drug program. If a member is fully eligible for dual coverage, LIS copayments are based on the member's income level. Plan members who have LIS and are on maintenance medications can participate in the **90-day** retail pharmacy initiative. The copayment for a **90-day** supply is a **one-month** copayment (based on the member's income level). Members must go to a participating retail pharmacy. Mail-order pharmacies are also available to Plan members.

The UPMC Medicare Special Needs Plans' formulary provides a listing of covered drugs. To view the UPMC Medicare Special Needs Plans' outpatient prescription drug benefit:

- See ***UPMC Medicare Special Needs Plans' Pharmacy Program***, Pharmacy Services, Chapter J.

Providers also may check a member's benefits online at **www.upmchealthplan.com/snp.** Or they may call the UPMC Health Plan's **Interactive Voice Response (IVR)** system at **1-866-406-8762**.

Closer Look at Injectable Medications

Injectable medications, when administered by a provider during an office visit, may be covered under the medical plan when billed with the office visit.

Preventive Services

UPMC Medicare Special Needs Plans offer members the following preventive services. Providers are encouraged to recommend these services and follow up with members about their results.

- Abdominal aortic aneurysm screening
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular screening
- Cervical and vaginal cancer screening (Pap test and pelvic exam)
- Colorectal cancer screening
- Counseling to prevent smoking and tobacco use
- Diabetes screening
- Influenza vaccine
- Hepatitis B vaccine
- HIV screening
    - **NOTE**: HIV screening is covered for members with Medicare who are pregnant and members at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once **every 12 months** or **up to three times** during a pregnancy
- Intensive behavioral counseling for cardiovascular disease
- Intensive behavioral therapy for obesity
- Medical nutrition therapy services
- Personalized prevention plan services (Annual Wellness visits)
- Pneumococcal vaccine
- Prostate cancer screening (Prostate Specific Antigen (PSA) test only)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

- Screening for depression in adults
- Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation (counseling to stop smoking)
- Welcome to Medicare Physical Exam (initial preventive physical exam)

Skilled Nursing Facility

A **three-day** hospital stay **is not required** prior to admission into a skilled nursing facility (SNF) for UPMC Medicare Special Needs Plan members. This permits a member to be admitted to an SNF directly from the emergency department, from home, or from a brief inpatient stay, as long as the care is medically appropriate.

To obtain prior authorization for skilled nursing facility admissions, providers must contact **Utilization Management** by submitting a prior authorization request through Provider OnLine at **www.upmchealthplan.com/providers.** Care in a network skilled nursing facility has a benefit period of up to **100 days**, which is calculated by Original Medicare methodology.

Providers can verify benefits for specific members at **www.upmchealthplan.com/snp.** Or they can call the UPMC Health Plan **Interactive Voice Response (IVR**) system at **1-866-406-8762.**

Closer Look at SNF Benefit Periods

A benefit period begins the day the UPMC Medicare Special Needs Plan member is admitted to a skilled nursing facility and ends when the member has been discharged for at least **60 consecutive days**. If the member is admitted to a skilled facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a member may have.

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. UPMC Medicare Special Needs Plan members must go to a participating urgent care center if they are in the service area when services are needed.

➢ See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Routine Vision Services

Routine vision benefits are provided by UPMC Vision Care. UPMC Vision Care provides routine vision services, including exams and eyewear (glasses or contacts).

UPMC Medicare Special Needs Plans include coverage for routine eye exams **once every year**. Eyewear (one pair of glasses or contacts) is covered **every year** up to an annual limit.

For additional information, contact **UPMC Vision Care** at **1-877-262-7870** for information specific to the member's plan benefits.

Plan members are eligible to receive Medicare-covered eye exams and eyewear.

For information on balance billing for non-routine vision services:

- See ***Restrictions on Member Cost-Sharing Instructions***, UPMC Medicare Special Needs Plans, Chapter M.

Closer Look at Cataract Surgery

Care for diagnosis and treatment of eye diseases and conditions, including eyewear following cataract surgery, is provided through the medical benefits for UPMC Medicare Special Needs Plan members.

Services Not Covered

The following items and services <u>are not covered</u> under Original Medicare or by UPMC Medicare Special Needs Plans:

- Acupuncture.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Cosmetic surgery or procedures, unless due to an accidental injury or to improve a malformed part of the body. However, pursuant to the Women's Health and Cancer Rights Act of October 1998, federal law has required insurance companies to provide certain specific benefits for reconstructive surgery after mastectomy. UPMC Medicare Special Needs Plans cover reconstructive surgery following a mastectomy.

  - **NOTE: The Plans provide coverage for:**

    - Reconstruction of the breast on which the mastectomy was performed.
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
    - Prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas.
    - Coverage for inpatient care following a mastectomy for the length of stay determined by the attending physician.
    - One home health care visit within **48 hours** of discharge, when the discharge occurs within **48 hours** of the admission for the mastectomy, to comply with Pennsylvania law that mandates coverage for mastectomy shall include the visit. The patient and the attending physician must collaborate in making the decisions concerning these procedures. Coverage is subject to the Plan's payment provisions.

- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services.

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.

- Experimental medical and surgical procedures, equipment, and medications, unless covered by original Medicare or under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by the Plan and Original Medicare to not be generally accepted by the medical community.

- Fees charged by a member's immediate relatives or household members.

- Full-time nursing care in a member's home.

- Homemaker services, including basic household assistance and light housekeeping or light meal preparation.

- Meals delivered to a member's home, unless otherwise specified in the member's plan benefit package.

  - **NOTE**: Both plans have a meal benefit requiring prior authorization after discharge to home from either a hospital inpatient stay, observation stay, or a skilled nursing facility stay.

- Naturopath services (uses natural or alternative treatments).

- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a member with diabetic foot disease.

- Personal items in a member's room at a hospital or skilled nursing facility, such as a telephone or a television.

- Private duty nurses.

- Private room in a hospital, except when it is considered medically necessary.

- Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids. However, eyeglasses are covered for members after cataract surgery.

- Reversal of sterilization procedures, gender confirmation surgery, and nonprescription contraceptive supplies.

- Routine foot care, except for the limited coverage provided according to Medicare guidelines, unless otherwise specified in the member's plan benefit package.

- Routine hearing exams, hearing aids, or exams to fit hearing aids, unless otherwise specified in the member's plan benefit package.

- Services considered not reasonable and necessary, according to the standards of original Medicare, unless these services are listed by the Plan as covered services.

- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under the UPMC Medicare Special Needs Plan, the Plans will reimburse veterans for the difference. Members are still responsible for cost-sharing amounts.

- Supportive devices for the feet, except for orthopedic or therapeutic shoes for members with diabetic foot disease.

- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.

The Plans **will not** cover the excluded services listed above. Even if the member receives the services at an emergency facility, the excluded services are still not covered.

Member Appeals and Grievances

Appeals

All UPMC Medicare Special Needs Plan members have the right to appeal any decision regarding payment or any failure to approve, furnish, arrange for, or continue what the member believes are covered services.

Members also may appeal any denial of payment for services that they believe the UPMC Medicare Special Needs Plan is required to pay for (including non-Medicare-covered benefits). Members may file an appeal or have an authorized representative file the appeal for them.

UPMC Medicare Special Needs Plan members should contact the **UPMC Medicare Special Needs Plan Health Care Concierge team** at **1-800-606-8648** (**TTY:711**) to discuss the appeal process. Members who do not speak English as their primary language should contact the **UPMC Medicare Special Needs Plan Health Care Concierge team** at **1-800-606-8648**, where they will be connected with language-translation services representatives contracted by UPMC Medicare Special Needs Plans.

- **NOTE:** The Health Care Concierge team's hours of operation change twice a year.

From October 1 through March 31	Seven days a week from 8 a.m. to 8 p.m.
From April 1 through September 30	Monday through Friday from 8 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.

Appointing an Authorized Representative

Members may appoint a family member, friend, physician, or attorney to act as their authorized representative when filing an appeal by following the steps below.

Members may obtain the necessary form by calling the **UPMC Medicare Special Needs Plans Health Care Concierge team** at **1-800-606-8648 (TTY:711).** Members who do not speak English as their primary language should contact the **Health Care Concierge team** at **1-800-606-8648**. The form is called an **Appointment of Representative Form**.

- **NOTE:** The Health Care Concierge team's hours of operation change twice a year.

From October 1 through March 31	Seven days a week from 8 a.m. to 8 p.m.
From April 1 through September 30	Monday through Friday from 8 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.

- **NOTE**: An Appointment of Representative Form **is not required** for the member's treating physician, who is a medical doctor, to file a pre-service appeal on the member's behalf.

The form is also available on the UPMC Health Plan website in the Medicare section at: **www.upmchealthplan.com/medicare/appointment-of-representative.aspx.**

1. **Furnish the member's name, Medicare number, and a statement appointing an individual as the member's authorized representative.**
    - For example, "I (member name) appoint (name of representative) to act as my authorized representative in requesting an appeal from UPMC Medicare Special Needs Plan regarding the denial or discontinuation of medical services."

2. **Obtain signature of the member.**
    - The member must sign and date the statement.

3. **Obtain signature of the member's representative.**
    - The member's authorized representative also must sign and date the statement.

4. **Include the signed statement with the appeal.**
    - The member must include the signed statement with the appeal.

Filing an Appeal

UPMC Medicare Special Needs Plans accept written requests for standard reconsideration (appeal) of services or payments that are filed by phone, mail, or faxed within **60 calendar days** of the notice of the initial organization determination:

UPMC Medicare Special Needs Plans
Appeals/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7520

If the UPMC Medicare Special Needs Plans make a fully favorable decision on an appeal, it notifies the member and authorizes or provides the service as expeditiously as the member's health requires, but no later than **30 calendar days** after receiving the appeal for a pre-service standard reconsideration. Favorable post-service payments for services would be paid within **60 calendar days**.

If the UPMC Medicare Special Needs Plans are unable to make a fully favorable decision, it forwards the case to a CMS independent review entity as expeditiously as the member's health requires, but no later than **30 calendar days** after receiving the appeal for pre-service issues and no later than **60 calendar days** after receiving the appeal for post-service issues.

UPMC Medicare Special Needs Plan members have the right to an expedited review by a **Quality Improvement Organization (QIO)** when they disagree with the decision of the UPMC Medicare Special Needs Plan decision to deny, reduce, or terminate services from a comprehensive outpatient rehabilitation facility (CORF), home health agency, inpatient rehabilitation, long term acute care, or a skilled nursing facility.

The QIO will inform the UPMC Medicare Special Needs Plan and the provider of the request for a review. The UPMC Medicare Special Needs Plan may need to present additional information required by the QIO to make a decision. The provider should be aware that he or she may need to provide additional information. Based on the expedited time frames, the QIO decision should take place by **close of business of the day coverage is to end**.

Alert—Expedited Appeal Procedures

An expedited appeal may be filed if the member believes his or her life, health, or ability to regain maximum function is in immediate jeopardy and the UPMC Medicare Special Needs Plan fails to provide medically necessary covered services. The member, his or her health care provider, or an authorized representative should call the **UPMC Medicare Special Needs Plan Health Care Concierge team** at **1-800-606-8648** (**TTY: 711**) to ask for an expedited appeal. Members who do not speak English as their primary language should contact the **UPMC Medicare Special Needs Plans Health Care Concierge team** at **1-800-606-8648** where they will be connected with language-translation services representatives contracted by UPMC Medicare Special Needs Plans.

- **NOTE:** The UPMC Special Needs Plans Health Care Concierge team hours of operation change twice a year.

From October 1 through March 31	Seven days a week from 8 a.m. to 8 p.m.
From April 1 through September 30	Monday through Friday from 8 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.

The UPMC Medicare Special Needs Plan is responsible for gathering all necessary medical information relevant to the member's request for reconsideration; however, it may be helpful to include additional information to clarify or support the request. The UPMC Medicare Special Needs Plan will make a decision about the request within **72 hours.**

- Favorable decisions will be authorized within the **72 hours**.
- Non-favorable decisions will be forwarded to the IRE for review within **24 hours** of the communication to deny coverage.

Alert—Provider Medical Records Obligations

Providers are contractually required to comply with record requests related to member appeals and grievances in a timely manner. UPMC Health Plan, DOH, PID and DHS, and any other governing State or Federal regulatory agency shall have access to records, medical, or otherwise, for the purpose of investigation of appeals and grievances. Compliance with this section may be accomplished by submitting electronic copies of the records requested.

UPMC Medicare Special Needs Plans' Model of Care

At UPMC Health Plan, providing the best care means establishing a model of care consistent with the unique characteristics of the members enrolled in UPMC Medicare Special Needs Plans and using a whole-person approach to address these distinctive issues.

UPMC Medicare Special Needs Plan members face chronic and often co-occurring physical and behavioral health conditions. These members also face complex psychosocial issues (poverty, homelessness, addiction, and lack of resources) that impact their ability to effectively manage their care.

Through the integration of physical, behavioral, social, medical, and community resources, the UPMC Medicare Special Needs Plans' Model of Care (MOC) aims to address barriers that impact the members' ability to self-manage care and coordinate care management needs.

This MOC involves members by assisting them in the development of self-management plans and explaining and managing their Medicare and Medicaid benefits. Accomplishing this will improve health outcomes, access to essential services, coordination and seamless transitions of care, appropriate utilization of services, and member satisfaction.

The Centers for Medicare & Medicaid Services (CMS) requires that all contracted providers receive basic training about the UPMC Medicare Special Needs Plans' MOC to better establish components, methods, and management programs of care as envisioned by UPMC Medicare Special Needs Plans.

The following information describes the basic components of the MOC, explains how UPMC Health Plan's care management programs work (and how contracted providers can work with these programs), and further describes the essential role of providers in delivering the MOC.

Many integral components play a part in the successful MOC. It is important to understand the role that each of these components plays in providing the best care to UPMC Medicare Special Needs Plan members.

Model of Care Elements

Table M1: Description of the SNP-Specific Target Population

UPMC *for Life* Dual	
Service Area (Counties)	**UPMC *for Life* Dual (H4279)** Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Butler, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northampton, Perry, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, and York counties. **UPMC *for Life* Dual (H7123)** Bucks, Chester, Delaware, Montgomery, Philadelphia
Largest County by Membership	Allegheny
Average Age	61.9
Gender	Female 63% Male 37%
Medical Assistance Status	Yes
Institutional Status (90+ days)	Possibly
Behavioral Health Concerns	Substance Use Disorder Depression
Top Five Disease Conditions by Prevalence	Hypertension Hyperlipidemia Mental Illness (Serious Persistent) Osteoarthritis Diabetes

Staff Structure and Roles

UPMC Health Plan employs a matrix approach to the MOC structure and utilizes staff and providers across the organization to ensure the best possible support for members enrolled in these products. This includes staff and functions from Care Management (including Utilization Management and Pharmacy), Quality Audit, Enrollment, SNP Operations, Member Services, Claims Operations, Medicare Compliance, SNP Finance, and Appeals and Grievances. Clinical staff coordinate care for members with multiple providers and educate members about health management, including adjusting lifestyle and promoting self-management techniques. Senior Medical Directors and health plan administrators provide clinical and administrative leadership oversight to verify licensure and staff competency, review encounter data for appropriateness and timeliness of services, assure provider use of clinical practice guidelines, and ensure implementation of standards of care.

Interdisciplinary Care Team

The interdisciplinary care team (ICT) includes the member and any applicable caregivers, the member's PCP and other health care providers, and UPMC Health Plan health coaches (care managers) and clinical staff. The ICT is integral in bringing a multidisciplinary approach to the member's whole-person care. The ICT incorporates physical, behavioral, social, and functional needs in addition to assessing health care utilization patterns (e.g., medications, diagnostic procedures, Emergency Department (ED) visits, hospitalizations, and specialist care). Through the ICT, the member is assigned to a primary health coach who is responsible for bridging gaps in communication among ICT members.

Provider Network

The UPMC Medicare Special Needs Plans' provider network is made up of credentialed professionals from an array of clinical disciplines, including PCPs, physical and behavioral health specialists, nursing professionals, and allied health professionals (pharmacists, PTs, OTs, speech pathologists, lab specialists, and radiologists). In addition, the provider network includes comprehensive service centers such as acute care hospitals, skilled nursing facilities, rehabilitation centers, long-term care facilities, and ancillary facilities (e.g., outpatient and diagnostic service centers). This network is monitored and expanded to meet the needs of member demographics and members' health care conditions.

Model of Care Training

Initial and annual training provides information to individuals who are responsible for implementing the elements of the MOC to ensure access to essential services and to improve member health outcomes and satisfaction. In addition to network providers, training is provided to new and existing staff at UPMC Health Plan. Training includes membership characteristics for each UPMC Medicare Special Needs Plan, as well as key elements of the MOC, including staff structure, interdisciplinary care teams, provider network, health risk assessment (HRA), individualized care plan (ICP), communication network, care management programs for vulnerable subpopulations, and measurement of quality outcomes. Ongoing training includes information related to chronic conditions, evidence-based treatments, care of the elderly and fragile populations, end-of-life care, medication management, network services, cultural diversity, community programs, member engagement, communication skills, utilization management, and product updates.

Health Risk Assessment

The SNP Health Risk Assessment Tool/Health Assessment Survey (SNP HRAT/HAS) is a tool for gathering information from a member on self-perceptions of health status. The tool assesses the member's physical and behavioral health status, utilization of services, caregiver and daily living supports, social needs, and lifestyle risk factors. The assessment is used in the development of the individualized care plan based on the member's goals, identification of gaps in preventive services, and opportunities for improved self-management of chronic conditions. The SNP HRAT/HAS is required for newly enrolled members and is updated **annually**; members can complete it by mail, over the phone, or in person. Care managers and social workers call members who do not return the survey.

Individualized Care Plan

The Individualized Care Plan (ICP), developed in consultation with the member, is a central MOC component that empowers the member to become involved in his or her own care. The interdisciplinary care team uses the ICP to coordinate care and to refer the member for appropriate community services. The plan is focused on whole-person care and includes information from providers, caregivers, and the member, as well as information from claims data, utilization management, discharge planning, pharmacy, or other additional assessments.

Communication Network

UPMC Medicare Special Needs Plans employ a variety of structures and strategies to ensure constant communication between members, providers, and ICT members. Communication among ICT members is facilitated through HealthPlaNET (care management software) for care management tracking, utilization management, pharmacy management, and member history. Regular in-person or telephone meetings among ICT members are held; these meetings include a review of the ICP, ED and inpatient claims data, and specialist and pharmacy utilization. Written communication with members is prepared by the Marketing and Communications Department and includes welcome kits, newsletters, Summary of Benefits, and annual Evidence of Coverage. Health Care Concierges, Clinical Operations outreach representatives, and health coaches interact with members by phone. Providers, practice-based care managers, and mobile staff interact with members face-to-face. The Provider Network team facilitates provider communications. The team includes physician account executives, network managers, and the manager of pharmacy provider network services. In addition to regularly scheduled office visits, information is provided through regional provider meetings, provider advisory committee meetings, and telephone conferences; monthly email updates on new initiatives; a provider manual and monthly newsletters; and email communication.

Care Management for the Most Vulnerable Subpopulations

Certain subpopulation categories are more likely to have complex conditions or multifactorial issues that can be barriers to self-management. The MOC identifies these populations as vulnerable and requiring additional clinical, programmatic, and community support. Populations include members with complex conditions such as end-stage renal disease (ESRD), sickle cell disease, hemophilia, or a serious mental illness (SMI); members who are institutionalized; and members who are frail elderly, disabled, or near the end of life. Additional vulnerable populations include those who are prescribed multiple medications by multiple providers (polypharmacy) as well as those who frequently use the emergency department for nonemergency care. The MOC employs a variety of strategies for these populations.

Performance and Health Outcome Measurement

Developed by the Institute for Healthcare Improvement and supported by CMS administration, the **"Triple Aim Principles"** for improving health care in the United States guide evaluation on the effectiveness of a MOC. This pragmatic approach involves improving the health of the population, enhancing the member's experience of care, and reducing, or at least controlling, the per capita cost of care. The UPMC Medicare Special Needs Plans' MOC is evaluated based on enrollment and claims data, diagnostic test results, inpatient admissions and readmissions, ED utilization, PCP and specialist utilization, lifestyle risk factors and functional status change, quality of life, health management programs, the plan of care, provider and member satisfaction [including **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**], and member grievances and appeals.

UPMC Medicare Special Needs Plans' Model of Care–Care Management Programs

Disease-Specific Health Management Programs

Programs to assist in the management of chronic conditions have been developed as an enhancement to the UPMC Medicare Special Needs Plans' MOC. These programs target serious mental illness, diabetes, coronary artery disease, heart failure, COPD, asthma, and depression through evidence-based techniques, including motivational interviewing and "Coach on Call" materials (approved educational documents developed for the member and any applicable family member).

Designed from a whole-person paradigm, UPMC Medicare Special Needs Plans' health management programs monitor and assess the member's condition, adherence to treatment plans, lifestyle issues (e.g., smoking, nutrition, exercise, etc.), and other relevant health conditions. Members are grouped by intervention level (low, medium, or high) based on claims, pharmacy data, and gaps in care.

Closer Look at the Provider Role in Health Management Programs

UPMC Medicare Special Needs Plans provide the member's PCP with information regarding health management programs and how to best utilize these programs. This information is available to all network PCPs on the UPMC Health Plan website and in provider newsletters.

The ICT notifies PCPs when the member is initially enrolled in a health management program. The Provider Reporting tool will be used for updates, feedback, and metric-specific provider performance. PCPs will be contacted directly if information of an urgent nature is obtained and to provide specific feedback to aid in clinical decision-making.

Patient-Centered Medical Home

The patient-centered medical home (PCMH) program enhances the UPMC Medicare Special Needs Plans' MOC and helps PCPs implement a population management model for members with multiple chronic conditions and high utilization of services. The MOC employs additional support by practice-based care managers (PBCMs) in high-volume practice sites to collaborate with the member's PCP to coordinate the plan of care and to provide education to the member. In addition, PBCMs are responsible for follow-up telephone activity, ED follow-up, inpatient transition, and behavioral health care coordination–thereby providing service coordination and care management to improve health outcomes and improve the ease of navigating the health care system for members.

Closer Look at the Provider Role in the PCMH

PBCMs have a close working relationship with members' PCPs and can help facilitate services and provide education to help members achieve better health outcomes. Through access to patient registries for members with chronic conditions, PBCMs can identify gaps in care, contact the member to determine need, and obtain necessary physician orders proactively. The PBCM can also help the member prepare a list of questions for the PCP, thus ensuring treatment plan understanding and better appointment flow. The PCP may also direct a member with a newly identified chronic condition or those in need of additional support to the PBCM as a resource prior to leaving the office.

Connected Care™

For members with serious mental illness (SMI), the Connected Care™ program provides enhanced connection and coordination of care between physical health and behavioral health providers in outpatient, inpatient, and ED care settings and between Medicare and fee-for-service Medicaid benefits. Connected Care™ is based on the medical home model and encompasses an integrated care team and care plan to address medical, behavioral, and psychosocial health needs. This method encompasses a two-pronged approach to improve health (by decreasing gaps in care, improving medication adherence, improving the rate of preventive services, and reducing avoidable readmissions) and member satisfaction (by improving access to services and coordination of care). Each member has an integrated care plan, which is an essential component for provider notification of inpatient admissions, timeliness, and comprehensiveness of discharge planning and treatment.

Closer Look at the Provider Role in Connected Care™

Comprehensive physical and behavioral health care is the key component of Connected Care™. Communication among UPMC Health Plan, Community Care Behavioral Health, and the member's health care providers is essential to providing this wrap-around care. Providers are notified upon inpatient admission (physical or behavioral) or an ED visit by a member. In all cases, the provider is encouraged to work with UPMC Medicare Special Needs Plans' health coaches to resolve treatment issues with this vulnerable population.

Utilization Management and Transitions to Home

Through review of admissions and other services, Utilization Management (UM) nurses, as part of the ICT, identify vulnerable members at risk for decreased functional capacity or those with a newly identified diagnosis. Upon notice of admission, the UM nurse notifies care management to ensure that active and necessary communication occurs between parties for successful transitions between care settings and quality health outcomes. The designated health coach ensures that the plan of care is shared with providers in all care settings and includes the member's needs that may impact care transitions and discharge planning (e.g., ability for the member to provide self-care at home and resource needs following discharge). Referrals to mobile staff or an emergency medicine provider (Emed Health) are possible for in-home assessments that further assess the member's ability to self-manage, identify safety issues, and review medications and orders.

Closer Look at the Provider Role in Utilization Management and Transitions to Home

PCPs will be notified of care management involvement and outreach and any member's needs identified in the plan of care. The relevant practitioners will be contacted and asked to resolve specific medication issues such as polypharmacy concerns, including duplicate medications prescribed by multiple physicians, incorrect dosage, or conflicting medication instructions.

Emergency Department Utilization

UPMC Medicare Special Needs Plan members with high ED utilization and those with specific conditions are referred to a health coach for follow-up. The health coach assists with arranging follow-up care and provides education on condition management and appropriate use of the ED and discusses alternative methods for nonemergency care. The health coach additionally addresses barriers that may have resulted in the ED visit, member's use of PCP services, member's compliance with current treatments (including medication) as well as any additional orders received from ED clinical personnel, and any changes in treatment plan as a result of the ED visit.

Closer Look at the Provider Role in ED Utilization

The health coach will contact the PCP should specific issues be identified that require additional treatment or assessment. The health coach will assist the PCP by educating the member, helping the member make appointments, and coordinating services.

Pharmacy Interventions

The UPMC Medicare Special Needs Plans' MOC addresses medication management through the UPMC Health Plan Medication Treatment Management (MTM) program. The primary care practitioner is sent information on the member for whom specific MTM issues have been identified. A staff pharmacist provides support to the ICT to address pharmacy issues; the pharmacist participates in all care team meetings. The pharmacist alerts providers and members of the ICT to potential adherence or overuse issues by the member. In addition, the pharmacist (through recommendation to other ICT members or direct contact) identifies and assists the member with barriers to appropriate and effective medication therapy, including difficulty with copayments, side effects related to noncompliance, understanding of medication administration, and compliance issues related to timing of medication administration.

Closer Look at the Provider Role in Pharmacy Interventions

The primary ICT Health Plan member or the pharmacist will follow up with the prescribing practitioner to provide information on medications ordered by other providers, the member's prescription-filling habits, and compliance interventions. In addition, communication to the prescribing physician is provided through letters as a result of the MTM process. This may include therapeutic duplication, inappropriate medications for the elderly, potential drug/drug interactions, and inappropriate disease-specific therapy. The provider will also be offered information on prescribing patterns, UPMC Health Plan clinical initiatives, and other resources available to prescribing clinicians.

So, What Does This All Mean?

Success of the UPMC Medicare Special Needs Plans' Model of Care depends on communication and coordination between key stakeholders in the member's health and wellness, including UPMC Medicare Special Needs Plans' staff, the member, and the member's health care providers.

Providers play perhaps the most dynamic and wide-ranging role in the evolving health care environment, and they face the most difficult challenges.

UPMC Medicare Special Needs Plans aim to facilitate solutions to these challenges by collaborating with providers to integrate this unique model of care and care management programs into the traditional patient treatment structure.

By working together through the UPMC Medicare Special Needs Plans' Model of Care, the health and wellness of enrolled members can be improved, and their experience of care enhanced. Unnecessary costs can also be reduced.

Appendix A
Integrated Denial Notice

If a UPMC *for Life* and/or UPMC *for Life* Dual provider is considering a procedure that may not be covered by UPMC Health Plan, even if prior authorization is not required, a prior authorization must be requested before performing the procedure. A prior authorization request may be submitted through **Provider OnLine** at **www.upmchealthplan.com/providers**. If the request is approved, UPMC Health Plan will consider the procedure for reimbursement.

If the procedure is not approved, both the provider and the Member will receive an Integrated Denial Notice (IDN) from UPMC Health Plan explaining the denial. If the Member would like to move forward with the procedure, the provider must obtain a signed financial responsibility waiver from the Member and bill the Member directly for the service(s). Even if the provider receives a signed financial waiver an IDN is still needed to bill the member.

It is important to note that all steps in the approval process must occur **BEFORE** the procedure takes place. If the provider seeks approval **AFTER** the procedure, UPMC Health Plan can automatically deny the request with no Member liability.

Below are some general guidelines on covered procedures.

- **Excluded services** would include services not considered medically necessary, personal items in a hospital or skilled nursing facility, full-time home nursing care, custodial care, homemaker services, reversal of sterilization procedures, nonprescription contraceptive supplies, and naturopath services.

- **Services potentially covered** under specific conditions include experimental/investigative procedures when covered under a Medicare or plan-approved clinical trial; private hospital room if medically necessary; supportive devices for the feet; orthopedic shoes; and cosmetic surgery in cases of accidental injury, breast reconstruction, or other malformed body member.

- **Services not typically covered** but which may be based on plan design at UPMC Health Plan include routine/preventive dental care and routine chiropractic, podiatry, hearing, and vision services.

If providers are unsure about any of the guidelines or a specific procedure, it is strongly recommended that they request an authorization to avoid waiving all Member liability for the services. More information about these guidelines or the approval process can be obtained by contacting **Provider Services** at **1-866-918-1595,** Monday through Friday from 8:00 a.m. to 5:00 p.m.

Additional information can be found in:

- **Chapter 4, Section 3**, **of the Evidence of Coverage (EOC)** on Provider OnLine. The EOC can be found on the Eligibility Details page under Schedule of Benefits for the specific Member enrolled in the plan.

- **Chapter 4, Benefits and Beneficiary Protections, Section 160**, of the Medicare Managed Care Manual.

- **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance in the Medicare Managed Care Manual**; 40.12.1- Part C Notification Requirements

    - See ***Covered Benefits and Services for HMO and PPO Members***, UPMC *for Life*, Chapter F.

    - See ***Covered Benefits and Services***, UPMC Medicare Special Needs Plans, Chapter M.

Appendix B
Other Resources

Various forms, guidelines and other resources can be found on the UPMC Health Plan website at **www.upmchealthplan.com.**

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

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

➢ See **Medical Prior Authorization Resources** section

Hard copies are available upon request; contact **UPMC Medicare Special Needs Plans Provider Services** at **1-877-539-3080,** Monday through Friday from 8 a.m. to 5 p.m.