

Provider Standards and Procedures

- B.1** Table of Contents
- B.2** Provider Rights, Responsibilities, and Roles
- B.16** Provider Standards and Requirements
- B.26** Accessibility Standards
- B.31** Referrals and Coordination of Care
- B.37** Hospital Guidelines
- B.41** Provider Disputes
- B.47** Provider Credentialing
- B.53** Medical Assistance Revalidation Requirement
- B.55** Disclosure of Ownership and Control
- B.57** Provider Sanctioning
- B.59** Provider Termination
- B.60** Integrated Denial Notice

Provider Rights, Responsibilities, and Roles

Provider Rights

Providers have a right to:

- Be treated by their patients and other health care workers with dignity and respect.
- Receive accurate and complete information and medical histories for Members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in Members' treatment plans.
- Expect Members to follow their directions, such as taking the right amount of medication at the right times.
- Help Members make decisions about their treatment, including the right to recommend new or experimental treatments.
- Make a complaint or file an appeal against UPMC Health Plan and/or a Member.
 - See *Administrative Appeal*, Provider Standards and Procedures, Chapter B.
- Receive payments for copayments, coinsurance, and deductibles as appropriate.
- File a grievance with UPMC Health Plan on behalf of a Member, with the Member's consent.
 - See *Provider Disputes*, Provider Standards and Procedures, Chapter B.
- Have access to information about UPMC Health Plan's Quality Improvement programs, including program goals, processes, and outcomes that relate to Member care and services. This includes information on safety issues.
- Contact UPMC Health Plan Provider Services with any questions, comments, or problems, including suggestions for changes in the Quality Improvement Program's goals, processes, and outcomes related to Member care and services.
- A Peer review to discuss a Utilization Management denial decision with the physician who made the original decision. This is an informal process available to a provider/practitioner when a disagreement arises regarding a UPMC Insurance Services Division decision to deny coverage of care or services.
 - See *Prior Authorization*, Utilization Management and Medical Management, Chapter G.

Provider Responsibilities

Providers have a responsibility to:

- Comply with state agency and federal regulations including the disclosure (at a practice level) of ownership, controlling interest, and management information.
 - See *Disclosure of ownership and control*, Chapter B, for full details.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Treat Members with fairness, dignity, and respect.
- Not discriminate against Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency, as described in Title VI Civil Rights Act of 1964 at [justice.gov/crt/about/cor/coord/titlevi.php](https://www.justice.gov/crt/about/cor/coord/titlevi.php).
- Maintain the confidentiality of Members' protected health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
 - See *Provider Role in HIPAA Privacy Regulations*, Provider Standards and Procedures, Chapter B.
- Provide Members with a notice of privacy practices that clearly explains their privacy rights, the provider's obligation to protect Member's protected health information and how to contact the provider and file a complaint.
 - See *Provider Role in HIPAA Privacy Regulations*, Provider Standards and Procedures, Chapter B.
- Provide Members with an accounting of the use and disclosure of their protected health information in accordance with the requirements set forth under HIPAA.
 - See *Provider Role in HIPAA Privacy Regulations*, Provider Standards and Procedures, Chapter B.
- Allow Members to request restriction on the use and disclosure of their protected health information.
 - See *Provider Role in HIPAA Privacy Regulations*, Provider Standards and Procedures, Chapter B.
- Provide services that are medically necessary.
 - See *Glossary of Health Care Terms*, Glossary and Abbreviations, Chapter K.
- Provide Members, upon request, with access to inspect and receive a copy of their protected health information, including medical records.

➤ **Note:** Requests for copies of bills or other protected health information documentation by a Medical Assistance Member, his or her personal representative, or an attorney or insurance carrier for the purpose of legal action should be referred to the Department of Human Services’ Division of Third-Party Liability, as directed in **Medical Assistance bulletin #99-09-03, “Clarification of Procedures for Requesting Copies of Medical Assistance Recipients’ Bills.”**

- Provide clear and complete information to Members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow each Member to participate in the decision-making process.
- Tell a Member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment.
- Allow a Member who refuses or requests to stop treatment the right to do so, as long as the Member understands that, by refusing or stopping treatment, the condition may worsen or be fatal.
 - See *Advance Directives*, Provider Standards and Procedures, Chapter B.
- Respect Members’ advance directives and include these documents in the Members’ medical record.
 - See *Advance Directives*, Provider Standards and Procedures, Chapter B.
- Allow Members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- Allow Members to obtain a second opinion, and answer Members’ questions about how to access health care services appropriately.
- Collaborate with other health care professionals who are involved in the care of Members.
- Obtain and report to UPMC Health Plan any information regarding other insurance coverage.
- Identify and report suspected cases of abuse or neglect and follow reporting procedures according to the PA reporting requirements.
- Allow UPMC Health Plan to use physician and provider performance data for quality improvement activities.
- Review clinical practice guidelines distributed by UPMC Health Plan.
- Notify UPMC Health Plan in writing, **90 calendar days** in advance, if the provider is leaving or closing a practice.
- Comply with UPMC Health Plan’s Utilization Management program as outlined in the UPMC Health Plan Provider Manual.
 - See *Utilization Management and Medical Management Chapter*, Chapter G.

- Contact UPMC Health Plan to verify Member eligibility or coverage for services, if appropriate.
- Disclose overpayments or improper payments to UPMC Health Plan.
- Collect coinsurance, deductibles, or copayments in full for services rendered.
 - **Note: Exception** - Recognize Medicare eligible Qualified Medicare Beneficiary (QMB) or Special Needs Plan (SNP) Members and do not attempt to collect (balance bill) for the deductible, coinsurance, or copayments.
 - **Note: Exception** - If a UPMC Community HealthChoices Participant or a UPMC *for You* Member is unable to pay the copayment at the time of the service, the provider must provide the service and then bill the Participant or Member for the copayment.
- Invite Member participation, to the extent possible, in understanding any medical or behavioral health problems that the Member may have and to develop mutually agreed-upon treatment goals, to the extent possible.
- Provide Members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.



Closer Look at Interpreters and Cost

The Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 U.S.C. §12101, et seq., states that:

- Health care professionals or facilities cannot impose a surcharge on an individual with a disability directly or indirectly to offset the cost of the interpreter.
- The cost of the interpreter should be treated as part of overhead expenses for accounting and tax purposes.
- Tax relief is available for expenditures made toward interpreters.
- The Internal Revenue Service may allow a credit. This tax credit may be applied to reasonable and necessary business expenditures made in compliance with ADA standards in order to provide qualified interpreters or other accessible tools for individuals with hearing impairments.

- Participate in UPMC Health Plan data collection initiatives, such as HEDIS and other contractual or regulatory programs.



Closer Look at Electronic Clinical Data Delivery

UPMC Health Plan reserves the right to obtain ongoing access to data, charts and medical record information related to UPMC Health Plan Members. The provider or provider group is required to allow UPMC Health Plan ongoing access to this information to comply with state, federal, and NCQA clinical, risk, and quality reporting requirements.

As of January 2020, the Pennsylvania Department of Human Services (DHS) is beginning the transition to electronic (digital) clinical quality measures and requires managed care organizations to submit using the electronic quality data. To meet this DHS requirement, when the provider or the provider group has electronic clinical data, UPMC Health Plan offers a broad range of options to deliver this information. UPMC Health Plan's preference is for the providers to join and participate in a state Health Information Organization (HIO). When joining a HIO the providers need to contribute the data elements on a Continuity of Care Document (CCD) or a Quality Reporting Document Architecture (QRDA) file that would contribute to quality rates. The goal is to increase standardization and decrease the ongoing administrative burden for providers and UPMC Health Plan.

If a provider opts out of participating in a Pennsylvania HIO and submitting QRDA or CCD file elements needed, UPMC Health Plan reserves the right to access electronic clinical data through other file transfer methods (including, but not limited to direct EMR/clinical integration via HL7, Clinical Document architecture [CDA] or flat file transfer). In the situation that electronic data access is unavailable, the provider cannot opt out of granting UPMC Health Plan access to the data. UPMC Health Plan staff will work with providers to obtain the data by other methods such as visiting the provider's office and performing a manual review of records to obtain the needed information.

Additional information on how to choose a HIO can be obtained by accessing DHS' website at [dhs.pa.gov/providers/Providers/Pages/Health Information Technology/Choose-your-HIO.aspx](https://dhs.pa.gov/providers/Providers/Pages/Health-Information-Technology/Choose-your-HIO.aspx).

UPMC Community HealthChoices and UPMC *for You* providers (PCP and Specialists) also have the responsibility to:

- Provide care to Members in accordance with the required appointment standards and waiting time frames established by the Department of Human Services (DHS). A UPMC Community HealthChoices and a UPMC *for You* 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 **1 hour** when the physician encounters an unanticipated urgent medical condition visit or is treating a patient with a difficult medical need.
- Not discriminate against Members on the basis of creed, sex, ancestry, marital status, sexual orientation, gender identity, MA status, language, program participation, income status, disease or pre-existing condition or anticipated need for health care.
- Provide care to Medical Assistance recipients during the period from their initial Medical Assistance eligibility determination to the effective date with UPMC Community HealthChoices and UPMC *for You*. This is referred to as the Fee-for-Service (FFS) Eligibility window. Medical Assistance enrolled providers are prohibited from denying medically necessary services to the newly eligible Medical Assistance recipient during his/her FFS window. Providers must use the Member’s ACCESS or EBT card to access DHS’ EVS and to verify the Member’s eligibility until the Member/Participant receives an ID card from UPMC Community HealthChoices or UPMC *for You*. The ACCESS or EBT card will allow the provider the capability to access the most current eligibility information without contacting UPMC Community HealthChoices or UPMC *for You* directly. The provider will bill FFS during this time period.

UPMC Community HealthChoices Participants may not have an ACCESS or EBT card for medical services. Providers must still use the DHS’ EVS to verify Participant’s eligibility using the Participant number on the UPMC Community HealthChoices card.

➤ See *Medical Assistance bulletin #99-13-05*, effective February 2013.

- Not charge Members for missed appointments (no-shows).
 - See *Medical Assistance bulletin #99-10-14*, effective December 2010.
- Assure Members that if they exercise their Medical Assistance Member rights regarding their care, it will not affect the way they are treated by their UPMC Community HealthChoices or UPMC *for You* provider.
- Contact new Members identified in lists provided by UPMC Community HealthChoices and UPMC *for You* who have not had an encounter during the **first six months** of enrollment, or who have not complied with established scheduling requirements. Provider shall document the reasons for noncompliance, where possible, as well as efforts to bring the Member’s care into compliance.

- Notify UPMC Community HealthChoices or UPMC *for You* if the provider has reason to believe a Member is misusing or abusing services or is defrauding a government health care program and/or UPMC Community HealthChoices and UPMC *for You*.
- Communicate effectively with Members, including those with communication barriers and not require family members to be used to interpret. Providers must arrange for an interpreter for Members who do not speak English or who communicate through American Sign Language or other forms of visual/gestural communication. The **Special Needs Department** at **1-866-463-1462** can help participating providers find a translator who can communicate with Members during their appointments.
- Observe DHS’ guidelines regarding standards of care, including the EPSDT and the Healthy Beginnings Plus programs.
 - See ***EPSDT Program***, UPMC *for You* chapter, Chapter E.
- Communicate with UPMC Community HealthChoices, UPMC *for You*, and other providers regarding identified special needs of Members.
- Not use any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.
- Participate **annually** in **at least one** UPMC Health Plan-sponsored education session.
- Provide primary and preventive care and act as the Member’s advocate, providing, recommending, and arranging for care.
- Identify, appropriately refer, and coordinate mental health, drug and alcohol, and substance abuse services.
- Document all care rendered, including any specialty or referral services, in a complete and accurate medical record and service record that meets or exceeds the Department of Human Services’ specification.
- Maintain continuity of each Member’s health care.
- Refer Members for needed specialty care and other medically necessary services, both in-network and out-of-network. Obtain prior authorization for out-of-network care.
 - See ***When to contact Utilization Management***, for information on out-of-network referral prior authorization requests, Utilization Management and Medical Management, Chapter G.



Clouser Look at Balance Billing

Medical Assistance is a payer of last resort. If a UPMC Community HealthChoices Participant or a UPMC *for You* Member has other insurance that would be primary to Medical Assistance, claims should be submitted to the primary insurance first. The remaining balance can be submitted to UPMC Community HealthChoices or UPMC *for You* for consideration. **Balance billing is not allowed.**

UPMC *for Life* (Medicare) and UPMC *for Life* Complete Care (HMO SNP) providers also have the responsibility to:

- Provide care to the Member within a reasonable period after request for care.

UPMC *for Life* Complete Care (HMO SNP) providers also have the responsibility to:

- Recognize UPMC *for Life* Complete Care Members and not attempt to collect (balance bill) Members for the deductible, coinsurance, or copayments.
 - See *Balance Billing Guidelines*, Provider Standards and Procedures, Chapter B.



Clouser Look at 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 health plan or state source for consideration. However, providers **may not** attempt to collect copayments (other than permitted Medical Assistance copayments) coinsurance, or deductibles from Members enrolled in UPMC *for Life* Complete Care, including during 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 calendar 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) beneficiary 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.

Balance Billing Guidelines for Secondary Medical Assistance Coverage

For Medicare or Special Needs Plan Members with a Community HealthChoices (Medical Assistance) plan as their secondary insurance, claims should be submitted to the Medicare plan first. The remaining balance can be submitted to the applicable Community HealthChoices plan for consideration. **Balance billing is not allowed.**



Closer Look at the Grace Period

What is a 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* Complete Care (HMO SNP), 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 calendar days**.

During this time, all 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 UPMC *for Life* Complete Care plan.

Provider Role in: ADA Compliance

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Providers' offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504 of the Rehabilitation Act of 1973, and other applicable laws. Providers may contact **Provider Services at 1-866-918-1595** to obtain copies of these documents and other related resources.

UPMC Health Plan requires that network providers' offices or facilities comply with this act. The office or facility must be architecturally accessible to individuals with mobility impairments (e.g., wheelchair-accessible) or have provisions to accommodate individuals in wheelchairs. This also refers to parking (if any), path of travel to an entrance, entrance to the building and the provider's office. Patient restrooms should be equipped with grab bars. Handicapped parking must be available near the provider's office and be clearly marked. A UPMC Health Plan representative will determine compliance during an on-site office/facility review by conducting an ADA accessibility survey. Providers will receive feedback describing areas requiring modifications to meet the ADA guidelines and have an opportunity to submit information on how they will address the issues.

Provider Role in: Compliance

UPMC Health Plan must comply with various laws, regulations, and accreditation standards in order to operate as a licensed health insurer. In order to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending, UPMC Health Plan established its distinct Corporate Compliance and Ethics Program.

UPMC Health Plan's Corporate Compliance and Ethics Program serves to assist contracted providers, staff members, management, and the Board of Directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

Reporting Compliance Concerns and/or Issues

UPMC Health Plan has established a Help Line for contracted providers, staff members, and other entities to report compliance concerns and/or issues without fear of retribution or retaliation. The **Help Line** number is **1-877-983-8442**, and it is available **24 hours a day, 7 days a week**. Callers may remain anonymous. Compliance concerns include, but are not limited to, issues related to compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Gramm-Leach-Bliley Act, and the Americans with Disabilities Act (ADA).

Responsibilities of the provider with regard to compliance:

- All UPMC Health Plan contracted providers are expected to conduct themselves according to UPMC Health Plan’s Code of Conduct & Ethics.
- All UPMC Health Plan contracted providers have a duty to *immediately* report any compliance concerns and/or issues.
- All UPMC Health Plan contracted providers should be alert to possible violations of the law, regulations, and/or accreditation standards, as well as to any other type of unethical behavior.
- UPMC Health Plan prohibits retaliation against contracted providers who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior.
- UPMC Health Plan prohibits retaliation against contracted providers who participate in an investigation or provide information relating to an alleged violation.

The success of UPMC Health Plan’s Corporate Compliance and Ethics Program relies in part upon the actions taken by our contracted providers. It is critical for our contracted providers to be aware of the goals and objectives of the UPMC Health Plan Corporate Compliance and Ethics Program, as well as of their responsibilities as providers.

For any questions regarding UPMC Health Plan’s Corporate Compliance and Ethics Program and/or a contracted provider’s responsibilities, providers should contact the **Senior Vice President Chief Risk and Compliance Officer**, at **412-454-8066** or the **Associate Vice President of Corporate Compliance**, at **412-454-5204**.

Provider Role in: HIPAA Privacy & Gramm-Leach-Bliley Act Regulations

All UPMC Health Plan policies and procedures include information to make sure that UPMC Health Plan complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act. Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations—as is the staff at UPMC Health Plan.

UPMC Health Plan has incorporated measures in all departments to make sure potential, current, and former Members’ protected health information, individually identifiable health information, and personally identifiable financial information are maintained in a confidential manner—whether that information is in oral, written, or electronic format. UPMC Health Plan employees may use and disclose this information only for those purposes permitted by federal legislation (i.e., for treatment, payment, and health care operations); by the Member’s written request; or if required to disclose such information by law, regulation, or court order.

A form authorizing the release of protected health information is available from UPMC Health Plan’s Member Services Department or from the UPMC Health Plan website. This form complies with the core elements and statements required by HIPAA privacy rules. This form must be completed, signed, and returned to UPMC Health Plan before UPMC Health Plan will release information.

All Members—including UPMC Community HealthChoices (Medical Assistance), UPMC *for Kids* (CHIP), UPMC *for Life* (Medicare), UPMC *for Life* Complete Care (HMO SNP), UPMC *for You* (Medical Assistance), and UPMC Health Plan (Commercial)—are annually provided with information explaining how to obtain a copy of UPMC Health Plan’s privacy practices and instructions on how to access their personal information. These documents clearly explain Members’ rights concerning the privacy of their individual information, including the processes that have been established to provide them with access to their protected health information and procedures to amend, restrict use, and receive an accounting of disclosures. The documents further inform Members of UPMC Health Plan’s precautions to conceal individually identifiable health information from Members’ employers.

UPMC Health Plan’s Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. UPMC Health Plan’s Privacy Statement and Notice of Privacy Practices can be viewed at upmchealthplan.com/privacy.aspx.

Provider Role in: Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage. UPMC Health Plan takes compliance with MHPAEA very seriously. For questions or concerns related to MHPAEA or MHPAEA compliance, contact the **Chief Compliance Officer** at **412-454-8066**, or the **Associate VP of Corporate Compliance & Ethics** at **412-454-5204**.

Provider Role in: Reporting Fraud, Waste, and Abuse to UPMC Health Plan

UPMC Health Plan has established a hotline to report suspected fraud, waste, and abuse (FWA) committed by any entity providing services to Members. The hotline number is **1-866-FRAUD-01 (1-866-372-8301) (TTY: 711)**, and it is available **24 hours a day, 7 days a week**. Voicemail is available at all times. Callers may remain anonymous and may leave a voicemail message if they prefer.

- **Note:** To report suspected fraud and abuse related to UPMC Community HealthChoices call **UPMC Community HealthChoices FWA line** at **1-844-881-4143 (TTY: 711)**.

Some common examples of fraud and abuse are:

- Billing for services and/or medical equipment that were never provided to the Member
- Billing more than once for the same service
- Billing or charging the Member for services paid for by UPMC Health Plan
- Dispensing generic drugs and billing for brand-name drugs
- Offering a prescription or prescription medications without seeing or treating the Member
- Offering gift(s), a prescription(s) or prescription medication(s), or money to Members in exchange for receiving treatment(s) or service(s)
- Falsifying records
- Performing and/or billing for inappropriate or unnecessary services
- Trading prescription drugs for sexual favors

Suspected fraud, waste, and abuse may also be reported via the website at upmchealthplan.com or the information may be emailed to specialinvestigationsunit@upmc.edu.

If reporting fraud, waste, and abuse by mail, mark the outside of the envelope “**confidential**” or “**personal**” and send to:

**UPMC Health Plan
Special Investigations Unit
Personal & Confidential (Do not open in mailroom)
PO Box 2968
Pittsburgh, PA 15230**

Information reported via the website, by email, or by regular mail may be done anonymously. The website contains additional information on reporting fraud and abuse.

Reporting Fraud, Waste, and Abuse to the Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to Medicare beneficiaries. The hotline number is **1-800-HHS-TIPS (1-800-447-8477)**, and it is available Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Reporting Fraud, Waste, and Abuse to the Department of Human Services

The Department of Human Services (DHS) has established a MA Provider Compliance Hotline to report suspected fraud, waste, and abuse committed by any person or entity providing services to Medical Assistance recipients. The **MA Provider Compliance Hotline** number is **1-866-379-8477** and operates Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Providers may also call the **Office of Inspector General Welfare Fraud Tip Line** at **1-800-932-0582** to report suspected fraud and abuse committed by a Medical Assistance recipient, such as Members who knowingly make false statements or representations to become eligible for Medical Assistance or Members who fail to provide all required information such as other insurance coverage. Members who commit fraud may be prosecuted under state criminal laws and federal fraud and abuse laws.

Some common examples of recipient fraud, waste and abuse are:

- Forging or altering prescriptions or orders
- Using multiple ID cards
- A Member loaning his or her ID card
- Reselling items received through the program
- Intentionally receiving excessive drugs, services, or supplies

Suspected fraud, waste and abuse may also be reported via the Office of Medical Assistance Program's website at dhs.pa.gov/about/Fraud-And-Abuse.

Information reported via the website or email also may be done anonymously. The website contains a MA Provider Compliance Hotline response form and additional information on reporting fraud, waste, and abuse.

Suspected fraud, waste, and abuse of services may also be reported by writing to the **Bureau of Program Integrity (BPI)** at the following address:

**Department of Human Services
Office of Administration
Bureau of Program Integrity
PO Box 2675
Harrisburg, PA 17105-2675**

DHS encourages providers to implement necessary policies, processes, and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the Medical Assistance (MA) Program. As part of these policies and procedures, DHS recommends that providers conduct periodic audits to identify instances where services were reimbursed inappropriately.

DHS established a **Self-Audit Protocol** that provides guidance to providers on the preferred methodology to return inappropriate payments. It encourages voluntary disclosure and communicates DHS' commitment to openness and cooperation. DHS' Self-Audit Protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation, or policy governing the Medical Assistance Program, or matters exclusively involving overpayments or errors that do not suggest violations of law.

The Self-Audit Protocol can be found on DHS' website at dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx.

Providers have several options for conducting self-audits and expediting the return of inappropriate payments to the Department:

- Perform **100 percent** claim review
- Provider-developed Audit Work plan for BPI approval
- DHS pre-approved Audit Work Plan with Statistically Valid Random Sample (SVRS)

If the provider identifies services that were inappropriately paid, they should promptly contact BPI to expedite the return of the inappropriate payment. When the provider properly identifies and reports to DHS inappropriate payments that are not fraudulent, DHS will not seek double damages, but will accept repayment without penalty. Penalties would normally range from **not less than \$11,665** and not more than **\$23,331 per false claim**, plus **three times the amount of any other damages** the U.S. government sustains because of the fraudulent claims.

- **Note:** The False Claims Act penalty amounts are subject to change. The amounts may increase each year with inflation.

The False Claims Act (31 U.S.C. sub sec 3729) makes it illegal to present or cause to be presented to the federal or state government a false or fraudulent claim for payment. This applies to U.S. government programs such as Medicaid, Medicare, Medicare Part D, and the Federal Employees Health Benefit Plan (FEHB). Any person in violation of this act could be subjected to fines and penalties.

Providers that have questions regarding this protocol may contact **BPI** at **717-772-1079** to discuss this protocol with the Provider Self-Audit Protocol Coordinator.

Provider Role in: Surveys and Assessments

UPMC Health Plan conducts a series of surveys and assessments of Members and providers in a continuous effort to improve performance. All providers are urged to participate when asked. UPMC Health Plan retains responsibility for monitoring provider actions for compliance with federal and state requirements.

Provider Standards and Requirements

Office Hours

Network Primary Care Providers (PCPs) must have a **minimum of 20 office hours** per week. In addition, they must be available for access **24 hours a day, 7 days a week, 365 days a year**. The office may have an after-hours monitoring answering service or paging system that will allow Members to either speak to the provider or leave a message/phone number for a call-back.

Verifying Provider Practice Information

The network management staff will verify important demographic information about a practice each time a staff member makes a service call. This verification is needed to ensure accuracy in various areas that concern providers, including claims payments and provider directories.

Maintaining accurate and up-to-date provider information for Members is critical. The Centers for Medicare & Medicaid Services (CMS), Department of Human Services (DHS), and Pennsylvania Insurance Department (PID) all require UPMC Health Plan to maintain a current and accurate provider directory. It is the responsibility of participating providers to ensure that their practice information is accurate in UPMC Health Plan's Provider Directory. Participating providers are required to notify UPMC Health Plan immediately of changes to their practice. In addition, the provider directory information must be reviewed and updated quarterly, even if there are no practice changes.

Information can be viewed by searching the online directory for the provider's name at upmchealthplan.com/find.

Information can be updated at upmchealthplan.com/providers/change.html.

- **Note:** The following information must be continually reviewed and updated:
- Ability to accept new patients
 - Street address
 - Phone number
 - Office hours
 - Hospital privileges
 - Any other information that affects the provider's availability to the Member

Failure to comply with this requirement may lead to provider sanctions and termination.



Alert—Product Termination

UPMC Health Plan requires notification of product termination in writing **60 calendar days** before the change to avoid improper claims payment and incorrect provider directory information.

Providers should notify UPMC Health Plan of any provider additions, practice changes, or corrections within **60 business days**. The following changes may be made through an online request form at upmchealthplan.com/providers/change.html.

- Addition/Deletion of a provider to/from a practice
- Addition or removal of an office location
- Changes to such information as phone/fax numbers, office hours, and hospital privileges
- Change in billing address or tax identification number
- Changes to product participation
- Provider terminations from the network

If the online form cannot be completed the following forms may be printed and mailed or faxed to UPMC Health Plan.

- Add or Remove Provider
- Add or Remove Office Location
- Office or Provider Information Change
- Change Pay to Address or Tax ID
- Change in Hospital Privileges
- Close/Reopen Panel
- Add/Drop Products
- Physician Termination

Provider may also notify UPMC Health Plan by faxing or mailing the information in a letter. The notification must be typewritten and submitted on business letterhead and must include the following information:

- Physician name
- Office address
- Billing address (if different than office address)
- Phone number and fax number
- Office hours
- Effective date
- W-9 tax form

Fax all provider changes to the **Provider Data Maintenance** at **412-454-8225**, or mail to:

**UPMC Health Plan
Provider Data Maintenance
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219**

Voluntarily Leaving the Network

Providers must give UPMC Health Plan at least **90 calendar days** written notice before voluntarily leaving the network. In order for a termination to be considered valid, providers are required to send termination notices by certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the Member's new provider and facilitate the Member's transfer of care **at no charge** to the Member or UPMC Health Plan.

UPMC Health Plan will notify affected Members in writing of a provider's termination, as applicable. If the terminating provider is a primary care provider (PCP), UPMC Health Plan will request that the Member elect a new PCP. If a Member does not elect a PCP prior to the provider's termination date, UPMC Health Plan will automatically assign one.



Alert — Notifying Affected Members

UPMC Community HealthChoices will send a letter to affected Participants **at least 45 days prior** to the provider's termination.

UPMC *for You* will send a letter to affected Members **within 30 days** of receipt of the provider's written notice of termination.

Providers must continue to render covered services to Members who are existing patients at the time of termination until the later of **60 calendar days**, or until UPMC Health Plan can arrange for appropriate health care for the Member with a participating provider.

Upon request from a Member undergoing active treatment related to a chronic or acute medical condition, UPMC Health Plan will reimburse the provider for the provision of covered services for up to **90 calendar days** from the termination date. The transition of care period may be extended, after consultation with the Member and provider, if determined to be clinically appropriate.

In addition, UPMC Health Plan will reimburse providers for the provision of covered services to Members who are in the **second or third trimester** of pregnancy extending through the completion of postpartum care relating to the delivery.

- **Note:** Providers will be reimbursed for covered services for Medical Assistance (UPMC Community HealthChoices and UPMC *for You*) Members and Participants during a pregnancy, regardless of the trimester they are in, through the postpartum period.

Exceptions may include:

- Members requiring only routine monitoring.
- Providers unwilling to continue to treat the Member.
- Providers unwilling to accept UPMC Health Plan payment and meet the same terms and conditions of participating providers.

Coverage for Providers on Vacation or Leave

While on vacation or leave of **less than 30 calendar days**, a network provider must arrange for coverage by another UPMC Health Plan participating provider. If a provider goes on an extended leave for **30 calendar days or longer**, the provider must notify **Provider Services** at the appropriate number listed below:

UPMC Community HealthChoices (Medical Assistance)	1-844-860-9303
UPMC <i>for Kids</i> (CHIP)	1-800-650-8762
UPMC <i>for Life</i> (Medicare)	1-877-539-3080
UPMC <i>for Life</i> Complete Care (HMO SNP)	1-877-539-3080
UPMC <i>for You</i> (Medical Assistance)	1-866-918-1595
UPMC Health Plan (Commercial)	1-866-918-1595

Locum Tenens Billing Arrangements

Substitute providers are often necessary to cover professional practices when the regular providers are absent for reasons such as illness, pregnancy, vacation, or continuing education. The regular provider should bill and receive payment for the substitute provider’s services as though these services were performed by the regular provider.

The regular provider may submit the claim and receive payment in the following circumstances:

- The substitute provider does not render services to patients over a continuous period of longer than **60 calendar days**.
- The regular provider identifies the services as substitute provider services by entering a **Q6 modifier** (services furnished by a locum tenens provider) after the procedure code.



Alert—An Example of Locum Tenens Billing

The regular provider goes on vacation on June 30 and returns to work on September 4. A substitute provider renders services to patients of the regular provider on July 2 and at various times, thereafter, including August 30 and September 2. The continuous period of covered services begins on July 2 and runs through September 2, a period of **63 calendar days**.

Since the September 2 services were furnished after a period of **60 calendar days** of continuous service, the regular provider is not entitled to bill and receive direct payment for these services. The substitute provider must bill for these services in his or her own name. The regular provider may, however, bill and receive payment for the services that the substitute provider rendered on his or her behalf during the period from July 2 through August 30.

24-Hour On-Call Coverage

PCPs and ob-gyns are required to provide **24-hour on-call coverage** and be available **7 days a week, 365 days a year**. If a provider delegates this responsibility, the covering provider must participate in UPMC Health Plan's network and be available **24 hours a day, 7 days a week, 365 days a year**.

Provider Scope of Services

Providers may bill UPMC Health Plan for all services performed for assigned Members. The services should be within the scope of standard practices appropriate to the provider's license, education, and board certification.

Provider Effective Date

The effective date for provider participation is the date that UPMC Health Plan Credentialing Committee approves the application.

For Specialists: In-Office Procedures

Specialists should perform procedures only within the scope of their license, education, board certification, experience, and training. UPMC Health Plan will periodically evaluate the appropriateness and medical necessity of in-office procedures.

In-Office X-Ray

A licensed radiology technician may perform in-office radiology services. The American College of Radiology must certify radiology facilities. A radiologist must review all x-rays.

In-Office Laboratory

Offices that perform laboratory services must meet all regulatory guidelines, including, but not limited to, participation in a Proficiency Testing Program and certification by the Clinical Laboratory Improvement Amendments (CLIA).

Guidelines Regarding Advance Directives

An advance directive is generally a written statement that an individual composes in advance of serious illness regarding medical decisions affecting him or her. The two most common forms of advance directives are a living will and a durable health care power of attorney. All adults have the right to create advance directives. In the event that an individual is unable to communicate the kind of treatment he or she wants or does not want, this directive informs the provider, in advance, about that individuals' treatment desires.

A Living Will

A Living Will takes effect while the individual is still living. It is a signed, witnessed written document concerning the kind of medical care a person wants or does not want if he or she is unable to make his or her own decisions about care.

A Durable Health Care Power of Attorney

A durable health care power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is unable to do so. A durable health care power of attorney can include instructions about any treatment the individual desires to undergo or avoid. Neither document becomes effective until the individual is unable to make decisions for him or herself. The individual can change or revoke either document at any time. Otherwise, the documents remain effective throughout the person's life.



Closer Look at Advance Directives

If a provider is unable to honor an advance directive, the individual may transfer to the care of a provider willing to carry out his or her wishes, as appropriate to the Member's benefit plan.

Legislative Basis for Advance Directives

The requirements for advance directives are outlined in the **Omnibus Budget Reconciliation Act of 1990**, which went into effect on December 1, 1991. If a Member decides to execute a living will or a durable health care power of attorney, the Member is encouraged to notify his or her PCP of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCP.

For more information about advance directives, contact:

The Pennsylvania Medical Society
Division of Communication and Public Affairs
77 East Park Drive
Harrisburg, PA 17105-8820
717-558-7750



Closer Look at the Legislation

Hospitals and other health care providers that participate in the Medicare Advantage and Medical Assistance programs must provide Members with written information about their right to make their own health care decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

Guidelines for Medical Record Documentation

UPMC Health Plan requires participating network physicians to maintain Member medical records in a manner that is accurate and timely, well-organized, readily accessible by authorized personnel, and confidential. Per UPMC Health Plan policy, all medical records must be retained for **10 years**.

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care.

UPMC Health Plan has adopted certain standards for medical record documentation, which are designed to promote efficient and effective treatment. UPMC Health Plan periodically reviews medical records to ensure that they comply with the guidelines below. Performance is evaluated as follows:

Table B1: Medical Record Documentation Guidelines

Category	Score	Action
Level 1:	Pass = 10 or more points including Required Element*	Compliant – No follow-up required
Level 2:	Fail = 0 to 9 points	Requires a corrective action plan and follow-up review in six months
Level 3:	Fail = Automatic fail if missing Required Element*	Requires a corrective action plan and a follow-up review in three months
<i>*Required Element = Organization and secure storage of medical records</i>		

Basic Information

- Place the Member's name or ID number on each page of the medical record.
- Include marital status and address, the name of employer, and home and work telephone numbers.
- Include the author's identification in all entries in the medical record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials, (e.g., progress notes need to include the signature and credentials of the provider of service).
- Date all entries.
- Ensure that the record is legible to someone other than the writer.

Medical History

- Indicate significant illnesses and medical conditions on the problem list. If the patient has no known medical illnesses or conditions, the medical record should include a flow sheet for health maintenance.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, providers should appropriately note this in the record.
- Document in an easily identifiable manner family, social, and past medical history, which may include serious accidents, operations, and illnesses. For children and adolescents (**18 years old and younger**), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For Members **14 years old and older**, note the use of cigarettes, alcohol, substances, and query substance abuse history.
- Physicians should indicate that they reviewed the history forms completed by staff. Review by and signature of another professional, such as a nurse practitioner or physician assistant, does not meet this requirement.
- Maintain an updated immunization record for patients **18 years old and younger**.
- Include a record of preventive screenings and services in accordance with the UPMC Health Plan Preventive Health Guidelines.
- Include, when applicable, summaries of emergency care, hospital admissions, surgical procedures, and reports on any excised tissue.

Treatment

- Document clinical evaluation and findings for each visit. Identify appropriate subjective and objective information in the history and physical exam that is pertinent to the Member's complaints.
- Document progress notes, treatment plans, and any changes in a treatment plan, including drugs prescribed.
- Document prescriptions telephoned to a pharmacist.
- Document ancillary services and diagnostic tests that are ordered and diagnostic and therapeutic services for which a Member was referred.
- Address unresolved problems from previous office visits in subsequent visits.
- Document the use of Developmental Delay and Autism Spectrum Disorder screening tools.
- Document referrals to **CONNECT** for Medical Assistance children **younger than five years old**, if developmental delays are suspected and the child is not receiving **CONNECT** services at the time of screening.

Follow-up

- Include on encounter forms or within the notes a notation regarding follow-up care, calls, or visits. Providers should note the specific time of recommended return visit in weeks, months, or as needed.
- Keep documentation of follow-up for any missed appointments or no-shows.
- Physicians should initial consultation, lab, imaging, and other reports to signify review. Review by and signature of another professional, such as a nurse practitioner or physician assistant, does not meet this requirement.
- Consultation, abnormal lab, and imaging study results must have an explicit notation of follow-up plans in the record.



Closer Look at Children’s Health Insurance Program Product (UPMC *for Kids*) and Medical Assistance Products (UPMC Community HealthChoices and UPMC *for You*) Outreach Requirements

PCPs, dentists, and specialists should conduct affirmative outreach whenever a Member misses an appointment and document the outreach in the medical record.

Such an effort shall be deemed to be reasonable if it includes **three attempts** to contact the Member.

Such attempts may include, but are not limited to:

- Written attempts.
- Telephone calls.
- Home visits.

At least one such attempt must be a follow-up telephone call.

- **Note:** For UPMC Community HealthChoices Participants with LTSS, their PCPs, dentists, and specialists may request that a Participant’s Service Coordinator conduct outreach. Service Coordinators will evaluate any barriers to Participant attendance at appointments and develop any necessary plan to facilitate and improve Participant compliance with the appointment scheduled.

Medical Record Confidentiality and Security

- Store medical records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only.
- Periodically train medical office staff and consistently communicate the importance of medical record confidentiality.

Medical Record Documentation Cloning

Documentation from a Member's previous visit(s) that is copied (cut and paste) or pulled from the electronic medical record (EMR) to auto populate the medical record is called Cloning.

Documentation that is the same from Member to Member is also Cloning. The medical record documentation for the visit must accurately reflect the Member's condition, treatment, and supporting medical necessity. Cloning could cause incorrect information to be placed in the medical record.

Documentation that does not support the service provided would be cause for UPMC Health Plan to deny the service, recoup payments, and review as a false claim,

➤ See *False Claims, Claims Procedures, Chapter H.*

Accessibility Standards

UPMC Health Plan follows accessibility requirements set forth by applicable regulatory and accrediting agencies. UPMC Health Plan monitors compliance with these standards annually.

Table B2: Accessibility Requirements

Type of Appointment	Scheduling Time Frame
Primary Care Providers	
Preventive Care	Within 3 weeks of the request
Regular and Routine	Within 10 business days of the request
Non-Urgent Sick Visit	Within 72 hours of the request (as clinically indicated)
Urgent	Within 24 hours of the request
Emergency	Immediately , or refer to the emergency room
Obstetrician-Gynecologists	
Annual Well-Woman Exam	Within 3 weeks of the request
Prenatal Care	
First Trimester	Within 10 business days of the request
Second Trimester	Within 5 business days of the request
Third Trimester	Within 4 business days of the request
High Risk	Within 24 hours of identification of high risk to a maternity care provider, or immediately, if an emergency exists
Emergency	Immediately , or refer to the emergency room
Specialists	
Urgent Care	Within 24 hours of the request
Emergency	Immediately , or refer to the emergency room
Routine Care	Within 10 business days of the request. <ul style="list-style-type: none"> ➤ Except for the following specialty providers, who must be scheduled within 15 business days of the request: <ul style="list-style-type: none"> • Dentist • Dermatology • Otolaryngology • Orthopedic Surgery

Table B2: Accessibility Requirements, cont’d.

Type of Appointment	Scheduling Time Frame
Specialists ... Continued	
Routine Care	<p>Within 10 business days of the request.</p> <ul style="list-style-type: none"> ➤ Except for the following specialty providers, who must be scheduled within 15 business days of the request: <ul style="list-style-type: none"> • Pediatric Allergy & Immunology • Pediatric Dentistry • 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



Alert—Scheduling UPMC Community HealthChoices Participants or UPMC *for You* Members Who Have AIDS or Are HIV-Positive

Primary care providers and specialists also have the responsibility to maintain adequate scheduling procedures to ensure an appointment is scheduled within **seven days** from the effective date of enrollment for any UPMC Community HealthChoices Participant or UPMC *for You* Member known to be HIV-positive or diagnosed with AIDS, unless the Member is already in active care with a PCP or specialist.

Emergency Services

In case of a medical emergency, the Member should attempt to call his or her PCP, if possible, explain the symptoms, and provide any other information necessary to help determine appropriate action.

The Member should go to the nearest emergency facility for the following situations:

- If directed by the PCP
- If the Member cannot reach the PCP or the covering provider
- If the Member believes he or she has an emergency medical condition

Members with an emergency medical condition should understand they have the right to summon emergency help by calling **911** or any other emergency telephone number, as well as a licensed ambulance service, without getting prior approval.

UPMC Health Plan will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.



Closer Look at Emergency Care

Emergency services do not require prior authorization. The hospital or facility must contact **Utilization Management** through **Provider OnLine** at upmchealthplan.com/providers on the **next business day or within 48 hours** after the emergency admission.

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.

When in UPMC Health Plan's primary service area, Members should contact their PCPs if they have an urgent medical need. UPMC Health Plan encourages providers to make **same-day** appointments available for their patients who call with unscheduled urgent health care needs. This improves the quality and continuity of patient care.

If Members are unable to contact their PCPs, and they believe they need care immediately, they should seek immediate medical attention. After such treatment, Members should contact their PCPs within a reasonable amount of time. A reasonable amount of time is typically considered **24 hours** unless there are extenuating circumstances.



Alert—Urgent Out-of-Area Care

If outside of UPMC Health Plan’s primary service areas, Members should seek medical attention immediately if they believe they need urgent care. Members should then call their PCPs, who, in turn, must contact **Utilization Management** by the **next business day** to ensure the claim is paid at the appropriate level. A request can be submitted through **Provider OnLine** at upmchealthplan.com/providers. If approved, UPMC Health Plan will give the provider a confirmation number. The PCP should note this number in the Member’s records.

- See *Out-of-Area Care*, Provider Standards and Procedure, Chapter B.

Out-of-Area Care

Out-of-area care should not be confused with out-of-network care. Out-of-area care is care rendered to Members traveling outside UPMC Health Plan’s primary service area. Out-of-network care is care sought by Members at a facility or provider not within the network appropriate to the Member’s benefit plan.

- See *Alert—Out-of-Network Referrals*, Provider Standards and Procedures, Chapter B.

All UPMC Health Plan Members are covered for emergency care when they travel outside the UPMC Health Plan network.

- **For UPMC Community HealthChoices Participants,**
 - See *Out-of-Area Care*, UPMC Community HealthChoices, Chapter N.
- **For UPMC for You Members,**
 - See *Out-of-Area Care*, UPMC for You, Chapter E.



Alert – Temporary Closed Panel Notification

Providers can inform UPMC Health Plan Network that they are not able to accommodate new patients for a temporary period by completing a request form found online at upmchealthplan.com/providers/change.html and checking the “**Close/Reopen Panel**” box. If the online form cannot be completed, the “Close/Reopen Panel” form may be printed and mailed or faxed to UPMC Health Plan. This information will then be posted in UPMC Health Plan’s web-based provider directory. The information will be updated when the provider notifies UPMC Health Plan that they are able to meet access standards.

Routine Care

Members must seek routine and preventive care from providers within their network. Utilization Management will review extenuating circumstances. Providers may contact Utilization Management through **Provider OnLine** at upmhealthplan.com/providers.

Injury or Illness

A Member who needs care while traveling outside the service area should contact his or her PCP, if applicable, within 24 hours, or as soon as reasonably possible, to inform the PCP of the nature of the illness or injury. The PCP must submit a request through **Provider OnLine** at upmhealthplan.com/providers to obtain authorization for services rendered by a non-participating provider. If Utilization Management authorizes the care, the level of benefits will be determined at that time.

UPMC Health Plan (Commercial) Members who receive a bill or have paid for services provided outside the area should submit those bills to UPMC Health Plan, using an Out-of-Network Care claim form. An Out-of-Network Care claim form is included in the UPMC Health Plan (Commercial) Member's information packet, or the Member can download a form at upmhealthplan.com. The Member also may call the **UPMC Health Plan Health Care Concierge team** at **1-888-876-2756 (TTY: 711)**, Monday through Friday from 7 a.m. to 7 p.m., and Saturday from 8 a.m. to 3 p.m.

Travel Assistance Program

Through a travel assistance program, Assist America, UPMC *for Life* (Medicare), UPMC *for Life* Complete Care (HMO SNP), and UPMC Health Plan (Commercial) Members have access to pre-qualified medical providers. Assist America will direct the Member to the closest, most appropriate medical facility, and will notify UPMC Health Plan accordingly.

If possible, Members should call **Assist America** at **1-800-872-1414** or **1-301-656-4152** (when within the United States) or **1-609-986-1234** (when outside the United States) to get a list of reliable doctors and/or safe medical facilities when they have a medical emergency and are more than **100 miles** from home. At no charge to the Member, Assist America will coordinate various services, which include, but are not limited to, the following:

- Medical referrals
- Medically supervised transportation to the Member's home
- Transportation of a family member to join the Member
- Emergency medical evacuation
- Care for minor children
- Critical care monitoring
- Dispatch of prescription medicine
- Emergency message transmission
- Hospital admission guarantee
- Return of mortal remains

➤ **Note: Member's obligation** - the Member still needs to call his or her PCP, if applicable, but the PCP does not need to call Utilization Management as long as the Member uses Assist America.

Referrals and Coordination of Care

Provider Role in Coordinating Care

UPMC Health Plan relies on each provider to ensure the appropriate use of resources by delivering quality care in the proper setting at the right time. UPMC Health Plan’s approach to accountability is based on the belief that providers know what is best for UPMC Health Plan Members. UPMC Health Plan relies on our providers to:

- Provide the appropriate level of care.
- Maintain high quality.
- Use health care resources efficiently.



Closer Look at Referrals

Providers are required to coordinate a Member’s care with other specialists, behavioral health providers, therapists, hospitals, laboratories, and facilities in the network appropriate to the Member’s benefit plan.

In addition, providers are required to refer Members to other Participating Providers (including but not limited to specialists, behavioral health providers, hospitals, laboratories and facilities). Use of network providers helps Members maximize medical benefits and reduce out-of-pocket expenses.

Failure to comply with this requirement may lead to provider termination. Network providers are responsible for determining the type of care the Member needs and the appropriate provider or facility to administer that care.

UPMC Health Plan **does not require a referral form**, but providers must follow a referral and coordination process to ensure high-quality care and accurate reimbursement for services.

The Role of the Referring Provider

Coordination of care requires that providers communicate with specialists, behavioral health providers, therapists, and other providers regarding Member’s care. In turn, those providers should reciprocate by informing the referring provider of their findings and proposed treatment. This sharing of information can be accomplished by telephone, fax, letter, or prescription. Providers also need to supply UPMC Health Plan with critical information needed to authorize certain types of care and process claims.

For UPMC Community HealthChoices Participants with LTSS, providers should also communicate with Participant’s Home and Community Based Services (HCBS) providers and service coordinators. HCBS services are authorized through the Participant’s person-centered service plan and it is important that providers work closely with Participant’s service coordinators and HCBS providers to understand the Participant’s needs.

Providers should follow these steps when referring a Member to a specialist:

1. Direct specialty care to providers, therapists, laboratories, and/or hospitals appropriate to the Member’s benefit plan.

The only time a provider should send a Member to specialists, therapists, laboratories, and hospitals outside the Member’s benefit plan is when extenuating circumstances require the use of an out-of-network specialist or facility or because the only available specialist or facility is not part of the Member’s benefit plan. The provider must have prior authorization from **Utilization Management** to refer a Member to an out-of-network specialist or facility.

➤ See *Alert—Out-of-Network Referrals*, Provider Standards and Procedures, Chapter B.

2. Correspond with the specialist/behavioral health provider.

The provider may call or send a letter, fax, or prescription to the specialist. The referring provider should communicate clinical information directly to the specialist without involving the Member.

3. Give the facility, specialist, or behavioral health provider the following referral information:

- Member’s name
- Reason for the referral
- All relevant medical information (e.g., medical records, test results)
- Referring provider’s name and Unique Provider Identification Number (UPIN) or National Provider Identifier (NPI) (This information is required in **boxes 17 and 17A** on the CMS-1500 claim form.)

➤ See *Required Fields on a CMS-1500 Claim form*, Claims Procedures, Chapter H.

➤ See the *UPMC Health Plan provider directory*, which is available online at upmchealthplan.com. For additional copies, call **Provider Services** at:

UPMC Behavioral Health Services (BHS)	1-866-441-4185
UPMC Community HealthChoices (Medical Assistance)	1-844-860-9303
UPMC <i>for Kids</i> (CHIP)	1-800-650-8762
UPMC <i>for Life</i> (Medicare)	1-877-539-3080
UPMC <i>for Life</i> Complete Care (HMO SNP)	1-800-606-8648
UPMC <i>for You</i> (Medical Assistance)	1-866-918-1595
UPMC Health Plan (Commercial)	1-866-918-1595



Alert—Out-of-Network Referrals

In order to send Members to out-of-network specialists or facilities, providers must obtain prior authorization from **Utilization Management** by submitting an authorization request through Provider OnLine at upmchealthplan.com/providers. Failure to get authorization will result in denial of the claim. The referring provider must give the reason for the out-of-network referral. If written information is required, it may be sent to:

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



Alert—Referrals required for the Healthcare Exchange

UPMC Health Plan offers several products that utilize a referral-based benefit design. These plans require a referral when seeking services with a specialist. The words “Referral Required” will be printed on the front of the Member’s ID card. The primary care physician is required to enter the referral utilizing the UPMC Health Plan Provider Online secure portal. The portal allows the physician to enter the referral for a specific physician, practice, or specialty for up to **90 calendar days** as a “Consult” or “Consult and Treat”. The referral is valid as of the date entered and **90 calendar days** forward. There are no retroactive referrals. The specialty office has the ability to log into Provider Online to verify that a referral has been entered. The provider must log into the secure portion of Provider Online to access the referral inquiry. Begin the process to obtain a log-in and password by accessing the following link: upmchealthplan.upmc.com/WebPortals/Requests/SecurityRequest.aspx.

To obtain assistance with the log-in and password process contact **Provider Services** at **1-800-937-0438** from 8 a.m. to 5 p.m., Monday through Friday.

- **Note:** A referral is not required for pediatric Members **younger than age 21**. In addition, a referral is not required for those Members seeking care for chemotherapy, ob-gyn preventive services or services from a pediatric specialist, or a behavioral health professional.
- **Note:** This referral process only applies to individuals who purchased a certain UPMC Health Plan coverage through the **Healthcare Exchange (Pennie)**. The referral process **does not apply** to the following plans: UPMC Community HealthChoices (Medical Assistance), UPMC *for Kids* (CHIP), UPMC *for Life* (Medicare), UPMC *for Life* Complete Care (HMO SNP), UPMC *for You* (Medical Assistance), and UPMC Health Plan (Commercial).

The Role of the Specialist for UPMC Health Plan (Commercial), UPMC *for Life* (Medicare), or Medicare Select

1. Verify whether the care was coordinated.

When a Member sees a specialist, the specialist's office needs to determine whether a provider coordinated the care, or the Member directly accessed the specialist for care. (If care was coordinated, the PCP's name and UPIN are required in **boxes 17 and 17A** on the CMS-1500 claim form.)

➤ See *Required Fields on a CMS-1500 Claim Form*, Claims Procedures, Chapter H.

If a provider coordinated the care ...

... collect any paperwork or check office records for communication from the referring doctor.

If the Member self-directed care to a specialist ...

... contact the PCP, if applicable, to obtain medical records and check to see if any diagnostic testing already has been completed to avoid duplicate testing.

If the Member does not have a PCP ...

... obtain a medical history and try to determine whether any prior diagnostic testing has been performed.

2. Determine the copayment.

If the visit is self-directed by a Member whose benefit plan does not require the selection of a PCP ...

... care is covered at a higher benefit level if the Member uses a network provider and at a lower benefit level if the Member uses an out-of-network provider.

3. Communicate findings.

The specialist must communicate findings and treatment plans to the referring provider within **30 calendar days** from the date of the visit. The referring provider and specialist should jointly determine how care is to proceed.



Closer Look at Referrals by Specialists

A specialist may coordinate the patient's care with another specialist as long as network providers are used. The specialist providing the care is responsible for communicating pertinent findings to the Member's PCP, when applicable, and for submitting the referring specialist's name and UPIN or NPI on the claim.

➤ See *Required Fields on a CMS-1500 Claim Form*, Claims Procedures, Chapter H.

The Role of the Specialist for Medical Assistance (UPMC Community HealthChoices and UPMC *for You*)

1. Verify that the PCP coordinated the care.

When a Member sees a specialist, the specialist's office needs to determine that the Member's PCP or ob-gyn coordinated the care. If there is no communication from the PCP or ob-gyn and the medical condition requires immediate treatment, the specialist should call the PCP or ob-gyn. (If care was coordinated, the PCP's name and UPIN are required in **boxes 17 and 17A** on the CMS-1500 claim form.)

2. Provide services indicated by the referral.

The specialist can provide only those services that are indicated by the referral. If the Member needs other services, the specialist must contact the PCP or ob-gyn. If the Member's condition is life-threatening or a degenerative or a disabling disease or condition, the PCP may approve an ongoing "standing" referral to a specialist. Members may also request a specialist to be their PCP by contacting the UPMC Health Plan Health Care Concierge team.

3. Communicate findings.

The specialist should communicate findings and a treatment plan to the Member's PCP. The PCP and specialist should then jointly determine how care should proceed, including when the Member should return to the PCP's care.



Alert—Referrals by Specialists to Other Specialists

Specialists cannot refer Members directly to other specialists. If the Member needs to see another specialist, the specialist must contact the Member's PCP or ob-gyn to discuss the need for a referral.



Alert—Out-of-Network Referrals by Specialists

Specialists cannot make out-of-network referrals. If a specialist believes an out-of-network referral is necessary, the specialist must contact the Member's PCP or ob-gyn. If a UPMC Community HealthChoices Participant or a UPMC *for You* Member requires a referral to out-of-network specialists and facilities, an authorization must be obtained from **Utilization Management** by submitting a prior authorization request through **Provider OnLine** at upmchealthplan.com/providers. The requesting 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**

Referrals for Ancillary Services for UPMC Community HealthChoices and UPMC *for You*.

UPMC Community HealthChoices and UPMC *for You* providers are required to coordinate referrals for ancillary services.

- See *Services Descriptions*, UPMC Community HealthChoices, Chapter N.
- See *Ancillary Services*, UPMC *for You* (Medical Assistance), Chapter E.

When referring a UPMC Community HealthChoices Participant or a UPMC *for You* Member for ancillary services, the PCP must follow these steps:

- 1. Obtain prior authorization from Utilization Management, if applicable.**
Providers should obtain prior authorization for out-of-network ancillary referrals or for ancillary services from **Utilization Management** by submitting a request through **Provider OnLine** at upmchealthplan.com/providers and entering the authorization request.
- 2. Communicate with the ancillary provider.**
After verifying eligibility, providers should send a letter or fax, or write a prescription for equipment and/or services.



Cl^oser Look at Medical Records for Coordination of Care and Referrals

Providers shall maintain an individual medical record for each UPMC Health Plan Member in accordance with applicable state and federal laws and regulations, customary medical practice, and UPMC Health Plan policies and procedures.

Providers agree that UPMC Health Plan's Members shall have access to their medical records **at no charge** and upon request. In the event that a Member disenrolls from UPMC Health Plan or transfers to a new participating provider/practitioner, the provider/practitioner shall cooperate in the transfer of all applicable medical records and information to the new provider/practitioner without charge to the Member.

Hospital Guidelines

At a Glance

UPMC Health Plan urges all providers to use the services of a network hospital. This will reduce costs, both to UPMC Health Plan and to Members, and ensure Members receive the highest quality care.

Providers who want to use out-of-network hospitals for nonemergencies must receive prior authorization from **Utilization Management** by submitting an authorization request through **Provider OnLine** at upmchealthplan.com/providers. The requesting 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**

Observation Status

Observation status applies to Members for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when:

- The Member's condition is expected to be evaluated and/or treated **within 24 hours**, with follow-up care provided on an outpatient basis.
- The Member's condition or diagnosis is not sufficiently clear to allow the Member to leave the hospital.



Closer Look at Observation Status

If a Member in observation status is admitted, authorization is required. Contact **Utilization Management** at **1-800-425-7800** at the time of service regarding the need to admit. If after hours, leave a message and a representative will follow up the **next business day**.

Network Hospitals

- **Inpatient Admissions**

Network providers may admit a Member to any network hospital appropriate to the Member's benefit plan. If the admitting provider is a specialist, the specialist must communicate the admission to the Member's PCP, if applicable, to ensure continuity and quality of care.

- **Emergency Admission**

Upon admitting a Member from the emergency department, the hospital should collect the following information:

- The practice name of the Member's PCP, if applicable
- The name of the Member's referring provider if referred for emergency care
- The name of the admitting provider if different from the referring provider or PCP

The hospital or facility must notify **Utilization Management** through **Provider OnLine** at upmchealthplan.com/providers within **48 hours** or on the **next business day** following the emergency admission.

- **Elective Admission**

To admit a UPMC Community HealthChoices Participant or a UPMC *for You* Member for an elective admission, the admitting provider must obtain prior authorization at least **seven business days** prior to the admission by submitting a request through **Provider OnLine** at upmchealthplan.com/providers. The admitting provider must work with the hospital to schedule the admission and any pre-admission testing.

Out-of-Network Hospitals

- **Emergencies**

When a Member is admitted to an out-of-network hospital for an emergency medical condition, the provider must contact **Utilization Management** at **1-800-425-7800** and ask to speak to a medical review nurse. The nurse may coordinate a transfer to a hospital appropriate to the Member's benefit plan when the Member is medically stable.

- **Nonemergencies**

Members should not be admitted to out-of-network hospitals unless prior authorization is obtained from Utilization Management for medically necessary services not available in the network. Providers must contact Utilization Management by submitting a prior authorization request through **Provider OnLine** at upmchealthplan.com/providers.

- **Inpatient Consultation and Referral Process**

If the admitting provider determines that a Member requires consultation with a specialist, the admitting provider must refer the Member to a network specialist appropriate to the Member's benefit plan. The referral should follow the hospital's locally approved procedures (e.g., consultation form, physician order form, etc.). The admitting provider and specialist jointly should determine how care should proceed. Coordination of care occurs through active communication among the PCP, the admitting provider, and the specialist.

Pre-Admission Diagnostic Testing

All pre-admission diagnostic testing conducted before a Member's medically necessary surgery or admission to the hospital is covered when performed at a hospital appropriate to the Member's benefit plan. Some procedures may require prior authorization.

If testing is completed within **72 hours** of the Member's admission, it is included with the admission. Otherwise, the testing can be billed separately.

Pre-admission diagnostic testing includes:

- Laboratory diagnostic tests.
- Radiological diagnostic tests.
- Other diagnostic tests, including electrocardiogram, pulmonary function, and neurological.

Transfers

Transfers Between Network Facilities

If a Member is admitted to a network hospital and needs to be transferred to another hospital, UPMC Health Plan requires that the Member be sent to a hospital appropriate to the Member's benefit plan. The transferring provider must coordinate the transfer with a representative at the receiving facility.

Providers must contact **UPMC Medical Transportation** at **1-877-521-RIDE (7433)** to arrange any type of transportation.

Transfers to Out-of-Network Facilities

UPMC Health Plan requires prior authorization for transfer to an out-of-network facility. The transferring provider must contact **Utilization Management** at **1-800-425-7800** and speak to a medical review nurse or submit a request through **Provider OnLine** at upmchealthplan.com/providers. Without prior approval, coverage will be denied.



Closer Look at Coordinating Transfers

Urgent and routine medical transportation must be provided by a network ambulance service. To coordinate transportation, providers must contact **UPMC Medical Transportation** at **1-877-521-RIDE (7433)**.

- **Note:** UPMC *for You* (Medical Assistance) providers located in the **Lehigh Capital zone do not need** to call UPMC Medical Transportation.

Discharges

Utilization Management works with the hospital's Utilization Management Department to coordinate discharge planning.

A discharge planner is available to assist in coordinating follow-up care, ancillary services, and other appropriate services. Contact **Utilization Management** at **1-800-425-7800** to speak to a discharge planner.

Hospital Delivery Notification

The hospital in which a UPMC *for You* newborn is delivered must fill out a **Hospital Maternity Profile form** and fax it to the **Medical Assistance Program** at **412-454-5731**.

For copies of the Hospital Maternity Profile form, providers should call **Provider Services**, at **1-866-918-1595**.

Additionally, as contracted Medical Assistance providers, hospitals and birthing centers maintain the responsibility of notifying (via fax or phone) the County Assistance Offices (CAO) **immediately** after the birth, then following up by mailing the **MA-112 (Newborn Eligibility Form)** to the applicable CAO **within three business days of the birth**. Additional copies of the form may be obtained by contacting the Pennsylvania Department of Human Services.

- See **Maternity Program**, Utilization Management and Medical Management, Chapter G.

Provider Disputes

If a provider disagrees with a decision by UPMC Health Plan to deny or reduce coverage of care or services, the provider has the right to appeal that decision.

Appeals fall into two categories: **administrative (non-medical necessity)** and **medical necessity**. A medical necessity appeal can be standard priority or expedited. Appeals are reviewed by UPMC Health Plan and assigned to the appropriate committee based on the nature of the dispute. A provider appeal may also be referred to as a dispute.

- **Note:** When using the term “appeals” related to a Member, “appeal” refers to the Member’s Appeal or Complaint and Grievance process.

If the provider initiates an appeal on behalf of a Member, with the written consent from the Member, as evidenced by documentation that comports with Pennsylvania law, the appeal is managed through the Member Complaint/Grievance/Appeal process, which includes expedited requests.

- See *Closer Look at Initiating an Appeal on Behalf of the Member* for full details.

Resubmitting a corrected claim due to minor error or omission is not an appeal.

Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address.

- See *Claims Addresses, Claims Procedures, Chapter H*.



Closer Look - Appeals must be submitted within 30 business days of the initial denial

A request for an administrative or a medical necessity appeal must be submitted in writing via mail or email within **30 business days** of the initial denial notification. The denial notification may be a denial letter, audit finding letter, or an Explanation of Payment (EOP) relevant to the issue being appealed.

- **Note:** The EOP can be viewed **24 hours a day, 7 days** a week by accessing **Provider OnLine** at upmchealthplan.com/providers.

The request must include the reason for the appeal and a copy of the medical records and other supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal, and include the date(s) of services being appealed.

For additional information or questions about the right to appeal or how to file an appeal, providers may call **Provider Services** at **1-866-918-1595**.

Administrative Appeal - (non-medical necessity)

Administrative appeals involve claims or authorization requests that have been denied for reasons other than a determination that the service at issue was not medically necessary.

Some examples are:

- The care was not coordinated with the PCP
- Prior authorization was required but not obtained
- Untimely claim submission
- UPMC Health Plan has determined that the service at issue is experimental or investigational

The following procedure outlines the Administrative appeal process:

1. Provider sends a written appeal to UPMC Health Plan.

Within **30 business days** of the initial denial, the provider sends a written appeal via mail or email to UPMC Health Plan at the following mail or email address as below, stating the reason the claim was denied (from the Explanation of Payment) and includes any supporting documentation as to why the provider believes the decision should be reversed. With the exception of audit appeals, multiple Members may not be submitted on one request.

**UPMC Health Plan
Provider Appeals
PO Box 2906
Pittsburgh, PA 15230-2906**

Email: HPtempproviderappeal@upmc.edu

➤ **Note:** For appeals submitted via email

- All relevant information must be attached to the email.
- If more than one email is required due to the size of attachments the subject line and the body must include notification that there are multiple emails for one appeal. For example: Part 1 of 3, Part 2 of 3, and Part 3 of 3.

2. Committee reviews the denial.

A committee of **one or more** UPMC Health Plan employees reviews administrative appeals and renders a decision. The committee reviews such appeals only once.

3. Committee makes decision.

The committee renders a decision within **60 business days** of the receipt of the appeal.

All decisions are final. If the administrative denial is upheld, the provider is notified in writing of the result within **10 business days** of the decision. If the administrative denial is reversed, the claim is adjusted within **30 business days** of the date of the decision. If the decision is reversed the provider receives notification of the decision of the review by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers**. Provider OnLine is available **24 hours a day, 7 days a week.**

Medical Necessity Appeal

Two levels of appeal are available to providers regarding denials based on medical necessity. Each is described in this section.

- See *Glossary of Health Care Terms* for the definition of medical necessity, Glossary and Abbreviations, Chapter K.

First-Level Medical Necessity Appeal

1. Provider sends a written appeal to UPMC Health Plan.

Within **30 business days** of the initial denial notification, the provider sends a written appeal via mail or email to UPMC Health Plan to the following mail or email address as below:

**UPMC Health Plan
Provider Appeals
PO Box 2906
Pittsburgh, PA 15230-2906**

Email: HPtempproviderappeal@upmc.edu

- **Note:** For appeals submitted via email
 - All relevant information must be attached to the email.
 - If more than one email is required due to the size of attachments the subject line and the body must include notification that there are multiple emails for one appeal. For example: Part 1 of 3, Part 2 of 3, and Part 3 of 3.
 - Requests for an expedited appeal cannot be sent via email.
- See *Alert – Expedited Medical Necessity Appeal* for full details.

The request must include the reason for the appeal and a copy of the medical records and other supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal and include the date(s) of service being appealed.

2. Provider/Practitioner reviews the appeal.

A provider/practitioner of the same/similar specialty of care that is being appealed, who was not involved with the initial determination, reviews the dispute.

3. Committee makes a decision.

A Committee comprised of UPMC Health Plan staff and a provider/practitioner, reviews the dispute and a decision is rendered within **30 business days**.

4. Provider receives notification of the decision.

If the medical necessity denial is upheld, the provider is notified in writing of the result within **10 business days** of the decision. If the medical necessity denial is overturned (reversed) the claim is adjusted within **30 business days** of the date of the decision. When the decision is reversed, the provider receives notification of the decision telephonically and/or by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provider OnLine** at upmchealthplan.com/providers. Provider OnLine is available **24 hours a day, 7 days a week**.

Second-Level Appeal

1. Provider submits a request for a Second-Level Appeal.

A provider who does not agree with the outcome of a First-Level Appeal can submit a request for a Second-Level Appeal following the procedure listed in First-Level Appeal. The request must include the reason for the appeal and a copy of the medical records and other supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal at a Second Level and include the dates(s) of service being appealed. A Second-Level appeal must be submitted within **30 business days** of the date on the First-Level appeal response letter.

2. Provider/Practitioner reviews the appeal.

A provider/practitioner of the same/similar specialty of care that is being appealed, who was not involved with the initial determination, reviews the dispute.

3. Committee makes a decision.

A Committee comprised of UPMC Health Plan staff, and a provider/practitioner reviews the dispute and a decision is rendered within **60 business days**.

4. Provider receives notification of the decision.

If the medical necessity denial is upheld, the provider is notified in writing of the result within **10 business days** of the decision. If the medical necessity denial is overturned (reversed), the claim is adjusted within **30 business days** of the date of the decision. When the decision is reversed, the provider receives notification of the decision telephonically and/or by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provide OnLine** at upmchealthplan.com/providers. Provider OnLine is available **24 hours a day, 7 days a week**.

Expedited Medical Necessity Appeal



Alert – Expedited Medical Necessity Appeal

The provider can request an expedited medical necessity review. Along with the request, the provider must submit a signed certification that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular medical necessity review process.

If the provider fails to submit a signed certification with the request, then UPMC Health Plan will decide the review within the standard time frames. After the request with accompanying certification is received, a decision is rendered as quickly as is warranted by the Member's condition but no later than **48 hours** after the request is received.

An expedited medical necessity review must be requested by calling **Provider Services** at **1-866-918-1595**.

Upheld – If the expedited medical necessity denial is upheld, the provider receives verbal confirmation of the Expedited Review decision within **48 hours**. Written confirmation is sent to the provider **within two business days** of the verbal notification of the decision. The written notification of the denial includes the reason for the denial.

Overtured – If the expedited medical necessity denial is overturned, the provider receives verbal notification of the decision within **48 hours** of receipt of the request. Any appropriate authorizations are added to the Utilization Management system.



Closer Look at Initiating an Appeal on Behalf of the Member

If the provider initiates an appeal with written consent from the Member or the Member's personal designated representative, the appeal is managed through the Member complaint/grievances/appeals process, which includes expedited appeals.

- The provider may ask the Member for his or her written consent to pursue an appeal at the time of treatment or service—but not as a condition of providing that treatment or service.
- An appeal of an adverse decision filed by a provider with written consent from the Member or the Member's personal designated representative is processed as a Member appeal and not a provider appeal. When providers file on behalf of a Member they have the same time frames as the Member in which to file.
- The provider may not bill the Member for services that are the subject of the appeal until the review has been completed or the Member's consent has been rescinded.
- The Member cannot file a separate appeal for the same denied treatment or service. If a Member wishes to do so, the Member must first rescind consent to the provider.
- The Member retains the rights to rescind the consent at any time during the grievance process, and the Member may continue with the grievance at the point at which the consent was rescinded.
- If the provider obtained consent to file an appeal and decides not to file on the Member's behalf the provider must notify the Member or the Member's legal representative **within 10 days** from receipt of the standard written utilization review denial and any decision letter from a first-level or second-level medical necessity appeal.
- The Member's consent is automatically rescinded if the provider fails to file a grievance.

Member’s written consent guidelines

- If a member requests that a provider file an appeal, the member must complete a consent form or write a letter. The consent form or letter of consent must include certain information, statements, and signatures that are required by the Pennsylvania Department of Health (**28 Pa. Code § 9.706**).

If the appeal request does not contain all the necessary requirements the appeal will be processed as a provider appeal and follow the standard provider time frames.

Providers can obtain a complaint consent form on the UPMC Health Plan website at embed.widencdn.net/pdf/plus/upmc/fkrst1jlmq/19PV994741---Provider-Appeal-on-Behalf-of-Member-WEB.pdf?u=oid6pr or by contacting UPMC Health Plan’s Provider Services Department at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

- **Note:** Filing time frames vary by product and the type of appeal, e.g., Complaint, Grievance, Appeal, First- or Second level, Expedited or External.
- See the following *UPMC Health Plan Provider Manual chapters* for Member Appeal, Complaints and Grievances procedures.

Chapter C	UPMC Health Plan (Commercial)
Chapter D	UPMC <i>for Kids</i> (CHIP)
Chapter E	UPMC <i>for You</i> (Medical Assistance)
Chapter F	UPMC <i>for Life</i> (Medicare)
Chapter M	UPMC <i>for Life</i> Complete Care (HMO SNP)
Chapter N	UPMC Community HealthChoices (Medical Assistance)

- See the following websites for *Member handbooks or Member guides* detailing the Member’s Complaint and Grievance procedures:

• Federal Employees Health Benefits	upmchealthplan.com/fehb
• UPMC Community Health Choices (Medical Assistance)	upmchealthplan.com
• UPMC <i>for Kids</i> (CHIP)	
• UPMC <i>for Life</i> (Medicare)	
• UPMC <i>for Life</i> Complete Care (HMO SNP)	
• UPMC <i>for You</i> (Medical Assistance)	
• UPMC Health Plan (Commercial)	upmc.widen.net/s/vps5rkn2ph

Provider Credentialing

The provider credentialing process involves several steps: request for network participation, application submission, primary source verification, on-site evaluation (if appropriate), a Credentials Committee review, and provider notification.

Application – Initial Credentialing

Providers interested in becoming a UPMC Health Plan provider should submit a network participation request online at upmchealthplan.com/providers/request.html or by calling **412-454-5264**.

If the request is approved, an application will be sent to the provider. The provider should fill in all of the requested information, sign, and date the application, and return it with any requested documents for initial processing to UPMC Health Plan by the following methods:

Email: ProviderNetworkInquiries@upmc.edu

Fax: 412-454-8225

Mail: UPMC Health Plan Network
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219

Application - Recredentialing

According to UPMC Health Plan guidelines, network providers must be recredentialled, at a **maximum of every three years** from the date of their initial credentialing.

The provider should fill in all the requested information, sign, and date the application they received in the mail and return it with any requested documents for processing to the address on the recredentialing application.

If the provider uses the Council of Affordable Quality Health (CAQH) database, the provider should update their information, attest to its accuracy in the CQAH database, and give UPMC Health Plan permission to view the information.

- **Note:** If the provider is a member of a UPMC Health Plan network Physician Hospital Organization (PHO), Physician Organization (PO), or another entity that UPMC Health Plan works with to credential/recredential providers, the provider should return the completed application to that organization for processing. Providers with questions about where to submit an application can contact **Provider Services** at **1-866-918-1595**.



Closer Look at the Application Process

The Credentialing and Network departments check the application for completeness. If documents or other information is missing, the credentialing staff will contact the provider office for the missing supporting documentation that would allow the credentialing process to move forward. Providers must provide a signature reflecting the new date of completion.

Primary Source Verification

The Credentialing Department checks each primary source to verify the following:

- Board certification
- Malpractice insurance coverage and history of liability claims
- Medical Assistance Sanctions
 - List of Excluded Individuals and Entities (LEIE)
 - Medichex Listing
- Medicare sanctions
- Registration with the Pennsylvania Department of Human Services as a Medicaid provider with a valid PROMISE ID for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You* providers
- Sanctions, restrictions, or suspensions of a state license
- Status of staff privileges at a network UPMC Health Plan hospital(s)
- Valid DEA or CDS certification for each state in which the provider practices
- Valid National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES)
- Valid, unrestricted license to practice in state(s) in which the practice resides
- Work history (This does not require primary source verification, although **gaps of six months or greater** must be clarified in writing by the provider for inclusion in the credentialing file.)

➤ See *Disclosure of Ownership and Control*, Provider Standards and Procedures, Chapter B.

On-Site Evaluation

UPMC Health Plan may contact providers to arrange an on-site evaluation of practice site(s) and/or medical record documentation. **At a minimum**, the following UPMC Health Plan standards will be assessed:

- Adequacy of waiting room and exam room space
- Availability of appointments
- Emergency care and CPR certification
- Hazardous waste elimination
- Medical equipment management
- Medical record documentation
- Medication administration
- Physical accessibility, availability, and appearance of practice site(s)
- Radiology, cardiology, and laboratory services (if applicable)

Provider Rights

Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information on the application to the primary source data. If any discrepancies are noted, the provider is notified in writing and has **14 calendar days** to forward the correct information in writing to the UPMC Health Plan Credentialing Department supervisor. The information must be sent in writing by mail or by fax from the facility or department from where the information originated (e.g., state license board, education facility, hospital, etc.). The Credentialing Department will document the receipt of the additional, corrected information in the provider's credential file. The corrected information will be reviewed by the Credentials Committee.

In addition, a provider has the right to review the information submitted in support of his or her application. If the provider discovers erroneous information on the application, the provider has the opportunity to correct this information before the Credentials Committee reviews it. The provider must initial and date the corrected information and re-sign and date the attestation form.

Upon request, a provider also has the right to be informed of the status of his or her credentialing or recredentialing application. The Credentialing staff will inform the provider of his or her credentialing status verbally or in writing depending upon the format (written/verbal) of the request submitted by the provider.

Providers' rights are documented on the UPMC Health Plan Provider Application. Changes to providers' rights will be communicated to providers in writing.

Credentials Committee Review

Completed credentialing files are then presented to the Credentials Committee for review and deliberation. A welcome letter and packet are sent to the providers once they are approved as providers in the UPMC Health Plan provider network.

Providers will be notified in writing if they are denied credentialing status for any reason. In the event that a provider wishes to appeal a credentialing denial decision, the request must be submitted via a letter addressed to the chairperson of the Credentials Committee.

- See *Credentialing Denials and Appeals*, Provider Standards and Procedures, Chapter B.



Alert—Credentialing Approval

UPMC Health Plan does not permit providers to render care to Members prior to credentialing approval for network participation.

Recredentialing Process

All providers must be recredentialled at a **maximum of every three years** from the date of their initial credentialing. The recredentialing process is the same basic process as that for credentialing, except that providers are also evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with UPMC Health Plan’s policies and procedures
- UPMC Health Plan sanctioning related to utilization management, administrative issues, or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality-of-care concerns

Applications for recredentialing are forwarded to the provider **about six months before** the provider’s recredentialing date to enable the credentialing process to be completed within the required period.



Alert—Recredentialing

Failure to return the completed recredentialing application and supporting documentation within the requested time limit may result in termination from the network. This is part of the UPMC Health Plan Provider contractual agreement.

Dual Credentialing and Recredentialing as a PCP and Specialist

UPMC Health Plan will consider, as an exception, requests from providers to participate as both a PCP and specialist when the provider:

- Meets UPMC Health Plan credentialing standards for each specialty requested.
- Provides documentation demonstrating adequate professional training, expertise, capacity, and capabilities to undertake such responsibilities for providing both primary care and specialty services.
- Agrees to be listed as a PCP in all member literature and accept membership.
- Agrees not to bill consultation charges for Members enrolled in the PCP practice regardless of the nature of the visit.

Credentialing and Recredentialing Issues

Board Certification

UPMC Health Plan requires that PCPs and specialists be board-certified in their respective specialties by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Physician Specialties, the Royal College of Physicians and Surgeons of Canada, or the Royal College of London, or the Australian College of Physicians.

Depending on the availability of qualified, board-certified physicians, the following exceptions may apply:

- Providers who meet all other qualifications but began practicing a specific scope of medical practice before the availability of board certification in their particular specialty. Such providers must have active admitting privileges at a UPMC Health Plan-affiliated hospital.
- Providers who are **within five years** of completion of an approved residency or fellowship in the specialty in which they practice.
- Providers who are Members of a group practice in which **50 percent** of the group physicians are board-certified in the requesting provider’s specialty.
- Providers who are practicing in federally designated underserved areas and meet all other credentialing standards, including:
 - Practicing in a requested specialty for more than **five years**
 - Active admitting privileges at a UPMC Health Plan network facility in the appropriate department

Malpractice Insurance

UPMC Health Plan requires that providers carry professional liability at **no less than** the current Pennsylvania Insurance Department minimum requirements or in accordance with the state requirements in which their practice resides. Providers must submit a copy of their current malpractice insurance face sheet with the amount of coverage and policy effective dates at the time of credentialing or recredentialing.

Credentialing Denials and Appeals

UPMC Health Plan will send a letter to a provider who has been denied credentialing. The letter will include appeal rights if applicable. If applicable, the provider may appeal a credentialing decision in the following manner:

1. Provider sends written request to the Credentials Committee chairperson.

- Providers should send requests for appeals to the following address:

**UPMC Health Plan Credentialing Department
U.S. Steel Tower, 42nd Floor
600 Grant Street
Pittsburgh, PA 15219**

2. The Credentials Committee chairperson sends the provider written notice of the hearing.

- The hearing date, time, and place, as well as the composition of the appeals committee, will be sent to the provider at least **30 calendar days** before the scheduled hearing date. The notice will include a request for the provider’s consent to disclose the specifics of his or her application and all credentialing documentation to be discussed at the hearing.
- The provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause for denial. Legal counsel also can represent the provider, as long as UPMC Health Plan is informed of such representation **at least seven business days** before the hearing.

3. The Appeals Committee conducts the hearing and sends recommendation to the Quality Improvement Committee (QIC).

- The Appeals Committee, consisting of **three** voting providers selected by the Credentials Committee chairperson, will deliberate without the provider present. Its decision will be by majority vote and will be forwarded to UPMC Health Plan’s Quality Improvement Committee (QIC) as a recommendation.

4. The QIC makes a decision and notifies provider.

- The QIC’s decision is final. Written notice of the QIC’s decision will be sent to the provider in an expeditious and appropriate manner and will include a written statement giving the basis of the decision.

Medical Assistance Revalidation Requirement

The Department of Human Services (DHS) must revalidate the enrollment of all providers at least every **five years**. In order to do this, DHS requires that all providers re-enroll at least every **five years** by submitting a fully completed Pennsylvania PROMISe™ Provider Enrollment Application for every active and current service location.

The provider may revalidate a PROMISe™ ID by accessing the following website:
provider.enrollment.dpw.state.pa.us

Additional information can be found in the **Medical Assistance bulletin #99-16-06** located at p.widencdn.net/4o81qa/Revalidation-of-MA-Providers.

A provider may obtain their next re-enrollment deadline by logging in to the provider portal for each service location. The revalidation date will be displayed in the masthead of the provider portal for each service location.

Background:

Section 6401(a) of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively known as the Affordable Care Act or ACA) added a requirement that states revalidate the enrollment of providers. The Department of Health and Human Services (HHS) issued implementing regulations, which can be found at **42 CFR 455.414(c)**. The ACA and implementing regulations require states to revalidate the enrollment of providers every **five years**.

Procedure:

To revalidate, providers must submit a complete Pennsylvania PROMISe™ Provider Enrollment Application to DHS for every active and current service location. Providers may view enrollment requirements and applications at dhs.pa.gov/provider/promise/enrollmentinformation.

Providers can submit their applications in one of the following ways, unless otherwise specified in the application instructions:

- **Online** through the Electronic Provider Enrollment Application available at:
provider.enrollment.dpw.state.pa.us
- **Email:** Ra-ProvApp@pa.gov
- **Fax:** 717-265-8284
- **Mail:** DHS/OMAP/BFFSP
Attention: Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045



Alert— Enrollment Application Changes

Providers must inform the Department of Human Services (DHS) of any changes to the information in their enrollment application, including changes in direct or indirect ownership and controlling interest of **5 percent or greater**, contract information changes, address changes (including email addresses), closed or invalid service locations, or any information that would render the information in their enrollment application or provider file inaccurate or incorrect.

Disclosure of Ownership and Control

UPMC Health Plan is required to obtain information from network providers concerning disclosure of ownership, controlling interest, and management information. UPMC Health Plan collects this information for all participating providers (“Disclosing Entity”). The information must be submitted within **30 days** of a request and updated at minimum **every three years** thereafter.

The following information is required:

- The identity of the Disclosing Entity
- The identity of all owners and others with a controlling interest in the Disclosing Entity
- Disclosure of familial relationships between owners and others with a controlling interest in the Disclosing Entity
- Disclosure of ownership or controlling interest in other Disclosing Entities
- The identity of officers, directors, and board members
- The identity of managing employees and agents
- Disclosure of ownership or controlling interest in subcontractors
- Disclosure of familial relationships between owners and others with a controlling interest in the Disclosing Entity and owners and others with a controlling interest in subcontractors.
- Identifying information includes, but it is not limited to:
 - Name.
 - Address.
 - Date of birth.
 - Social Security number (SSN).
 - Tax identification number (TIN).

An electronic form and definitions can be found at upmchp.us/provider-disclosure-form. Each section of the form must be completed unless the disclosing provider has attested that the section is not applicable. If any fields are left blank the form will not be processed and it will be returned for corrections and/or additional information.

Completion of the disclosure is a provider contractual obligation and condition of all providers for participation in the UPMC Health Plan network. Failure to submit the requested information may result in denial of network participation or termination of existing Provider Agreements.

After receiving a completed Disclosure of Ownership and Control form, UPMC Health Plan will review the data and run the names of all the entities and individuals disclosed through the Disclosure of Ownership and Control form against the Federal and State Database Check process. This process includes a review and comparison of the disclosed information to the following lists:

- U.S. Department of Health and Human Services Office of Inspector General’s (HHS OIG) List of Excluded Individuals/Entities (LEIE) database
- Medichex Listing
- Social Security Administration Death Master File (SSADMF)
- System for Award Management (SAM)
- Any other applicable state exclusion list, including other state Medicaid programs

The State also identifies individuals and entities that have been sanctioned, excluded, or terminated from participation in federal health care programs, and providers who have relationships with those individuals or entities. Any adverse information found during the disclosure and Federal and State Database Check process is submitted to the State.

In the event of a positive exclusion list match, UPMC Health Plan will notify the disclosing entity and request a written corrective action plan addressing the actions the disclosing entity has/is taking to address the status of the excluded party.

For additional information or assistance, providers should contact their UPMC Health Plan provider network contact or call **UPMC Provider Services at 1-866-918-1595**.



Closer Look at Exclusion Status

UPMC Health Plan is required under **42 C.F.R. §455.436** to check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents, and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration’s Death Master File (SSADMF), the National Plan and the Provider Enumeration System upon enrollment and re-enrollment; and check the LEIE and SAM **no less frequently than monthly**. UPMC Health Plan is required to check the SSADMF **at the time of initial enrollment and re-enrollment** as well as providers, owners, agents, and managing employees against the LEIE and SAM **on a monthly basis**.

Provider Sanctioning

UPMC Health Plan follows a **three-phase process** for addressing the actions of providers who fail to observe the terms and conditions of the provider agreement or UPMC Health Plan's policies and procedures.

The Quality Improvement Committee (QIC), made up of practicing physicians and UPMC Health Plan employees, sets the sanctioning guidelines and oversees any corrective or disciplinary action involving network providers.

Actions That Could Lead to Sanctioning

Actions that could lead to sanctioning fall into **three** main categories:

- Administrative noncompliance
- Unacceptable resource utilization
- Quality-of-care concerns

Administrative Noncompliance

Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of UPMC Health Plan. Examples include:

- Conduct that is unprofessional or erodes the confidence of UPMC Health Plan Members
- Direct or balance billing for services
- Failure to coordinate or cooperate with UPMC Health Plan's administrative, quality improvement, and utilization review and reimbursement procedures

Unacceptable Resource Utilization

Unacceptable resource utilization is a utilization pattern that deviates from acceptable medical standards and may adversely affect a Member's quality of care.

Quality of Care

A quality-of-care issue may arise from an episode that adversely affects the functional status of a Member or a pattern of medical practice that deviates from acceptable medical standards. For quality-of-care concerns, a severity scale is utilized. The severity level indicates adverse effects or potential adverse effects on the patient.

The sanctioning process and focused monitoring of the provider remain in effect for **no less than one year** from the date the provider is notified by a UPMC Health Plan medical director. The provider is notified when the process and follow-up activities are satisfied, and the sanctioning is no longer in effect. In instances of recurring similar noncompliance activities, UPMC Health Plan reserves the right to expedite the sanctioning process.

Corrective Action Phases

Corrective action is imposed in **three** phases, with providers entering successive phases only if they fail to adhere to the corrective action imposed in the previous phase.

Phase I—Education Phase

The **first** phase involves reviews and interviews between the provider and a UPMC Health Plan medical director. This phase also includes follow-up notices outlining the action expected of the provider.

Phase II—Continuing Education Phase

During the **second** phase, a medical director meets with the provider and provides focused monitoring of the provider's progress.

Phase III—Recommendation for Termination

In the **third** phase, if the provider has continued to exhibit unacceptable behavior or has not performed to acceptable standards, there will be a recommendation for consideration of termination.

- **Note:** If the UPMC Health Plan Medical Director determines that based on her/his sole discretion, a Member is in imminent danger because of the actions or inactions of a participating provider/practitioner, the UPMC Health Plan Medical Director may impose disciplinary action including:
- Immediate suspension or restriction of the practitioner/provider's network participation status; or
 - Phase III Recommendation for termination from the network

Phase III recommendation for termination may be invoked by the UPMC Health Plan's Medical Director based on the severity level without the provider/practitioner entering Phase I or Phase II of the process.

Provider Termination

The QIC, as part of the sanctioning process, may recommend the termination of a provider contract. The provider will be notified in writing and offered the opportunity to appear at a hearing, if appropriate.

The termination process involves the following steps:

1. Medical director notifies provider about termination.

The provider will be given notice stating that a professional review action was recommended and the reasons for the proposed action. The provider has the right to request a hearing within **30 calendar days**.

2. Provider may request a hearing.

If a hearing is requested, the provider will be given notice stating the place, time, and date of the hearing—to occur no later than **60 calendar days** after the date of the notice—and the names of witnesses, if any, expected to testify on behalf of UPMC Health Plan.

3. QIC appoints an Appeals Committee.

The QIC will appoint an Appeals Committee on an ad hoc basis. The QIC will not select as Members of the Appeals Committee anyone in direct economic competition with the provider who is the subject of the hearing or anyone who has previously voted on the action.

4. Appeals Committee conducts hearing and makes recommendations.

After the QIC recommends termination of participation status or other sanction, the Appeals Committee will hear the appeal from a provider if the QIC—in its sole discretion—offered the provider the opportunity to appeal. The Appeals Committee will conduct the hearing and recommend to the QIC that it accept, reject, or modify its original recommendation. The right to the hearing may be forfeited if the provider fails, without good cause, to appear.

At the hearing, the provider has the right to:

- Receive representation by an attorney or other person of the provider's choice.
- Have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation of the records.
- Call, examine, and cross-examine witnesses.
- Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law.
- Submit a written statement at the close of the hearing.

Upon completion of the hearing, the provider has the right to receive the written recommendation of the Appeals Committee from UPMC Health Plan in an expeditious and appropriate manner, including a written statement giving the basis of the decision.

Integrated Denial Notice

If a UPMC *for Life* (Medicare) and/or UPMC *for Life* Complete Care (HMO SNP) 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 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 a.m. to 5 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 Protection, 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 for Life Complete Care (HMO SNP), Chapter M.