

# *UPMC Health Plan Behavioral Health Services*

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## *At a Glance*

This section of the UPMC Health Plan Provider Manual contains information pertinent to behavioral health network providers who are providing services to Members of the following UPMC Health Plan products:

- UPMC *for Kids* (CHIP)
- UPMC *for Life* (Medicare)
- UPMC *for Life* Complete Care (HMO SNP)
- UPMC Health Plan (Commercial)

➤ **NOTE:** UPMC Health Plan does not manage behavioral health benefits for Medical Assistance Members; therefore, the information contained in this section does not apply to behavioral health services provided to UPMC *for You* Members or UPMC Community HealthChoices Participants.

Information frequently changes. Thus, *provider alerts* are published for the most up-to-date information for behavioral health network providers. *Provider alerts* will be sent to providers and made available on [upmchealthplan.com](http://upmchealthplan.com). Suggestions about how UPMC Health Plan can improve services to network behavioral health providers are welcome. Together, UPMC Health Plan and behavioral health providers can provide Members with a "seamless" system of high-quality behavioral health services and contribute positively to the communities and region.

The introductory pages below include a **summary table of behavioral health service authorization procedures**. Also, the tables contain more specific information regarding the following:

- Checking Member eligibility for behavioral health benefits
- Obtaining authorizations for certain behavioral health services
- Being a network behavioral health provider
- Improving the quality of behavioral health care
- Reporting fraud and abuse
- Submitting claims to UPMC Health Plan

For important contact information and a glossary of terms and abbreviations especially prepared for behavioral health providers:

- See *UPMC Health Plan Behavioral Health Services (BHS) Key Contacts – Table A1, Welcome and Key Contacts*, Chapter A.
- See *Glossary & Abbreviations*, Chapter K.

Any questions about material in the UPMC Health Plan Behavioral Health Services (UPMC Health Plan BHS) section of the UPMC Health Plan Provider Manual, call **UPMC Health Plan BHS at 1-866-441-4185**. Representatives are available **24 hours a day, 7 days a week**.

# *Providing Behavioral Health Services to UPMC Health Plan Members*

## **Behavioral Health Service Authorization Procedures**

Some behavioral health services require authorization. Obtaining authorization is essential (but not sufficient) for a claim for certain behavioral health services to be paid. Payment is also contingent upon other requirements including, but not limited to, Member eligibility, concurrent review requirements, and focused or retrospective care management reviews.

Network providers must submit authorization requests by logging into **Provider OnLine** at [upmchealthplan.com/providers](http://upmchealthplan.com/providers). Select the **Auth Entry/Inquiry** option from the main menu and follow the prompts.

Out-of-network providers must call **1-866-441-4185** to request prior authorization.

Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year.**

- See *Chapter A-Provider OnLine*, for complete Provider OnLine instructions for in- and out-of-network providers.

The following tables of behavioral health services outline applicable medical necessity criteria and which services and UPMC Health Plan products require prior authorization.

- **See tables:**
  - **Table L1** – Inpatient Mental Health
  - **Table L2** – Inpatient Detoxification, Drug and Alcohol (includes nonhospital facilities)
  - **Table L3** – Inpatient Rehabilitation, Drug and Alcohol (includes nonhospital facilities)
  - **Table L4** – Mental Health Residential Treatment
  - **Table L5** – Mental Health Partial Hospitalization Program
  - **Table L6** – Drug and Alcohol Partial Hospitalization Program
  - **Table L7** – Mental Health Intensive Outpatient Program
  - **Table L8** – Drug and Alcohol Intensive Outpatient Program
  - **Table L9** – Outpatient Behavioral Health Services, Mental Health and Drug and Alcohol

**Table L1: Inpatient Mental Health**

Service	Authorization Requirements
<p><b>Inpatient Mental Health</b></p>	<p>Inpatient Mental Health services <b>require prior authorization.</b></p> <ul style="list-style-type: none"> <li>➤ <b>NOTE: Exception</b> <i>UPMC for Kids (CHIP) does not require prior authorization for medically necessary in-network inpatient mental health services.</i></li> <li>• <b>Medical necessity criteria</b>, as set forth in <i>The Mihalik Group’s Medical Necessity Manual for Behavioral Health</i>, are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Adult Acute Inpatient Treatment: Mental Health, Child and Adolescent Acute Inpatient Treatment: Mental Health, or Geriatric Acute Inpatient Treatment: Mental Health levels in the Mihalik Manual for in-depth criteria.</i></li> </ul> </li> <li>• <b>Continued-stay reviews</b> can be completed on the last covered day authorized or <b>one business day</b> after the <b>last covered day</b> authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.</li> </ul>

**Table L2: Inpatient Detoxification, Drug and Alcohol  
(includes non-hospital facilities)**

Service	Authorization Requirements
<p><b>Inpatient Detoxification, Drug and Alcohol (includes non-hospital facilities)</b></p>	<p>Inpatient Detoxification, Drug and Alcohol services <b>require prior authorization</b>. These services include nonhospital facility-based services.</p> <ul style="list-style-type: none"> <li>➤ <b>NOTE: Exception</b> <i>UPMC for Kids (CHIP) does not require prior authorization for medically necessary in-network inpatient detoxification.</i></li> <li>• <b>For adults</b>, American Society for Addiction Medicine (ASAM) adult patient placement criteria are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See ASAM Level 4 WM – Medically Managed Intensive Inpatient or Level 3.7 WM – Medically Monitored Inpatient sections.</i></li> </ul> </li> <li>• <b>For adolescents</b>, ASAM adolescent patient placement criteria are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See ASAM Level 4 WM – Medically Managed Intensive Inpatient or Level 3.7 WM – Medically Monitored Inpatient sections.</i></li> </ul> </li> <li>• <b>Continued-stay reviews</b> can be completed on the last covered day authorized or <b>one business day</b> after the <b>last covered day</b> authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.</li> </ul>

**Table L3: Inpatient Rehabilitation, Drug and Alcohol  
(includes non-hospital facilities)**

Service	Authorization Requirements
<p><b>Inpatient Rehabilitation, Drug and Alcohol (includes non-hospital facilities)</b></p>	<p>Inpatient Rehabilitation, Drug and Alcohol services <b>require prior authorization</b>. These services include nonhospital facility-based services.</p> <ul style="list-style-type: none"> <li>➤ <b>NOTE: Exception</b> <i>UPMC for Kids (CHIP) does not require prior authorization for medically necessary in-network inpatient rehabilitation.</i></li> <li>• <b>For adults</b>, ASAM adult patient placement criteria are used for decision regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 4 - Medically Managed Intensive Inpatient Services or Level 3.7 – Medically Monitored Intensive Inpatient sections.</i></li> </ul> </li> <li>• <b>For adolescents</b>, ASAM adolescent patient placement criteria is used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 4 - Medically Managed Intensive Inpatient Services or Level 3.7 – Medically Monitored Intensive Inpatient Services sections.</i></li> </ul> </li> <li>• <b>Continued-stay reviews</b> can be completed on the last covered day authorized or <b>one business day</b> after the <b>last covered day</b> authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.</li> </ul>

**Table L4: Mental Health Residential Treatment**

Service	Authorization Requirements
<p><b>Mental Health Residential Treatment</b></p>	<p>Mental Health Residential Treatment <b>requires prior authorization.</b></p> <p>➤ <b>NOTE: Exception</b>  <i>UPMC for Kids (CHIP) does not require prior authorization for medically necessary in-network residential mental health services.</i></p> <ul style="list-style-type: none"> <li>• <b>Medical necessity criteria</b>, as set forth in <i>The Mihalik Group’s Medical Necessity Manual for Behavioral Health</i>, are used for decisions regarding prior authorization and continued stays.                             <ul style="list-style-type: none"> <li>➤ <i>See Adult Sub-Acute Inpatient Treatment: Mental Health, Child and Adolescent Sub-Acute Inpatient Treatment: Mental Health or Geriatric Sub-Acute Inpatient Treatment. Mental Health levels in the Mihalik Manual for in-depth criteria.</i></li> </ul> </li> <li>• <b>Continued-stay reviews</b> can be completed on the last covered day authorized or <b>one business day</b> after the <b>last covered day</b> authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.</li> </ul>

**Table L5: Mental Health Partial Hospitalization Program**

Service	Authorization Requirements
<p><b>Mental Health Partial Hospitalization Program</b></p>	<p>Any medically necessary in-network claim for a Mental Health Partial Hospitalization Program will be considered for payment <b>without an authorization.</b></p> <p>For Members <b>with out-of-network benefits</b>, any medically necessary out-of-network claim for a Mental Health Partial Hospitalization Program will be considered for payment at the out-of-network benefit level <b>without an authorization.</b></p> <p>For Members <b>without out-of-network benefits</b>, a claim for out-of-network Mental Health Partial Hospitalization Program <b>requires prior authorization.</b> Providers must call <b>UPMC Health Plan BHS at 1-866-441-4185</b> to obtain authorization.</p> <p>Care managers are available to providers <b>24 hours a day, 7 days a week, 365 days a year.</b></p> <ul style="list-style-type: none"> <li>• The <i>Mihalik Group’s Medical Necessity Manual for Behavioral Health</i> is used for decisions about prior authorization and continued stays.                             <ul style="list-style-type: none"> <li>➤ <i>See Adult Partial Hospital Treatment: Mental Health, Child and Adolescent Partial Hospital Treatment: Mental Health, or Geriatric Partial Hospital Treatment: Mental Health Sections in the Mihalik Manual.</i></li> </ul> </li> </ul>



**Table L6: Drug and Alcohol Partial Hospitalization Program**

Service	Authorization Requirements
<b>Drug and Alcohol Partial Hospitalization Program</b>	<p>Any medically necessary in-network claim for a Drug and Alcohol Partial Hospitalization Program will be considered for payment <b>without an authorization.</b></p> <p>For Members <b>with out-of-network benefits</b>, any medically necessary out-of-network claim for a Drug and Alcohol Partial Hospitalization Program will be considered for payment at the out-of-network benefit level <b>without an authorization.</b></p> <p>For Members <b>without out-of-network benefits</b>, an out-of-network claim for Drug and Alcohol Partial Hospitalization Program <b>requires prior authorization.</b> Providers must call <b>UPMC Health Plan BHS at 1-866-441-4185</b> to obtain authorization.</p> <p>Care managers are available to providers <b>24 hours a day, 7 days a week, 365 days a year.</b></p> <ul style="list-style-type: none"> <li>• <b>For adults</b>, ASAM adult patient placement criteria are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 2.5 – Partial Hospitalization Program Services section.</i></li> </ul> </li> <li>• <b>For adolescents</b>, (ASAM) adolescent patient placement criteria are used for decisions about prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 2.5 – Partial Hospitalization Program Services section.</i></li> </ul> </li> </ul>

**Table L7: Mental Health Intensive Outpatient Program**

Service	Authorization Requirements
<p><b>Mental Health Intensive Outpatient Program</b></p>	<p>Any medically necessary in-network claim for Mental Health Intensive Outpatient Program will be considered for payment <b>without an authorization.</b></p> <p>For Members <b>with out-of-network benefits</b>, any medically necessary out-of-network claim for Mental Health Intensive Outpatient Program will be considered for payment at the out-of-network benefit level <b>without an authorization.</b></p> <p>For Members <b>without out-of-network benefits</b>, an out-of-network claim for Mental Health Intensive Outpatient Program <b>requires prior authorization.</b> Providers must call <b>UPMC Health Plan BHS at 1-866-441-4185</b> to obtain authorization.</p> <p>Care managers are available to providers <b>24 hours a day, 7 days a week, 365 days a year.</b></p> <ul style="list-style-type: none"> <li>• The <i>Mihalik Group’s Medical Necessity Manual for Behavioral Health</i> is used for decisions about prior authorizations and continued stays. <ul style="list-style-type: none"> <li>➤ <b>See <i>Adult Intensive Outpatient Treatment: Mental Health, Child and Adolescent Intensive Outpatient Treatment: Mental Health or Geriatric Intensive Outpatient Treatment: Mental Health</i> sections in the <i>Mihalik Manual</i>.</b></li> </ul> </li> </ul>

**Table L8: Drug and Alcohol Intensive Outpatient Program**

Service	Authorization Requirements
<p><b>Drug and Alcohol Intensive Outpatient Program</b></p>	<p>Any medically necessary in-network claim for Drug and Alcohol Intensive Outpatient Program will be considered for payment <b>without an authorization.</b></p> <p>For Members <b>with out-of-network benefits</b>, any medically necessary out-of-network claim for Drug and Alcohol Intensive Outpatient program will be considered for payment at the out-of-network benefit level <b>without an authorization.</b></p> <p>For Members <b>without out-of-network benefits</b>, an out-of-network claim for Drug and Alcohol Intensive Outpatient program <b>requires prior authorization.</b> Providers must call <b>UPMC Health Plan BHS at 1-866-441-4185</b> to obtain authorization.</p> <p>Care managers are available to providers <b>24 hours a day, 7 days a week, 365 days a year.</b></p> <ul style="list-style-type: none"> <li>• <b>For adults</b>, ASAM adult patient placement criteria are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 2.1 – Intensive Outpatient Services section.</i></li> </ul> </li> <li>• <b>For adolescents</b>, ASAM adolescent patient placement criteria are used for decisions regarding prior authorization and continued stays. <ul style="list-style-type: none"> <li>➤ <i>See Level 2.1 – Intensive Outpatient Services section.</i></li> </ul> </li> </ul>

**Table L9: Outpatient Behavioral Health Services, Mental Health and Drug and Alcohol**

Service	Authorization Requirements
<p><b>Outpatient Behavioral Health Services, Mental Health and Drug and Alcohol</b></p>	<ul style="list-style-type: none"> <li>Any medically necessary in-network claim submitted for psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or drug and alcohol use disorders will be considered for payment <b>without an authorization.</b></li> <li>For Members <b>with out-of-network benefits</b>, out-of-network psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or substance use disorders <b>will pay at the Member’s out-of-network benefit level.</b> A provider can verify eligibility for out-of-network benefits based on the individual’s plan by calling <b>UPMC Health Plan BHS</b> at <b>1-866-441-4185.</b></li> <li>For Members <b>without out-of-network benefits</b>, out-of-network psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or substance use disorders, <b>will require a prior authorization.</b> To submit this request, complete the medical necessity form for out-of-network requests, which is located at <a href="https://p.widencdn.net/apb6mg/providers_mnf-oon_web">https://p.widencdn.net/apb6mg/providers_mnf-oon_web</a>. Fax the completed form to <b>412-454-2057.</b></li> </ul>



**Closer Look at Behavioral Health Service Authorizations**

An authorization is not a guarantee of payment for services rendered.

- Members are to be held financially harmless if the provider fails to follow the authorization procedures. Members cannot be billed for services if the provider fails to obtain the proper authorization.
- Providers need to routinely check with the Member concerning any change in their insurance coverage on a routine basis. Members may change insurance plans and neglect to inform the provider.
- Member benefits for each level of care vary according to the Member’s employer and/or the particular insurance plan in which the Member is enrolled. Discuss benefit limitations with the Member or call **UPMC Health Plan BHS** at **1-866-441-4185** to verify benefits. Representatives are available **24 hours a day, 7 days a week, 365 days a year.**
- It is important that providers notify UPMC Health Plan about any changes to contact information or services offered so that Members can be given accurate referral assistance.

UPMC Health Plan has developed specific procedures for behavioral health providers to follow when providing behavioral health services to UPMC Health Plan Members. These procedures were designed to:

- Verify that the services are covered.
- Arrange for each Member to receive the level of care required.
- Provide Member services in a seamless fashion.
- Promote quality of behavioral health care.

## Key Points

The following sections detail procedures for providing behavioral health services to UPMC Health Plan Members. As a part of UPMC Health Plan’s commitment to quality improvement, these procedures are updated as needed. These sections discuss the following:

- Verifying Member eligibility for behavioral health services covered by UPMC Health Plan
- Medical necessity criteria
- Obtaining prior authorizations and other utilization review activity
- Provider availability standards
- Standards for Member access to services (waiting time for appointments)
- Coordination of care, referrals, and transition of care to other providers
- Referral assistance for Members selecting behavioral health providers
- Statement regarding UPMC Health Plan policy on incentives
- Clinical practice guidelines of common behavioral health disorders
- UPMC Health Plan pharmacy formulary information
- Member rights and responsibilities

## Verifying Member Eligibility for UPMC Health Plan BHS

Claims for behavioral health services are paid when a Member is eligible to receive behavioral health services on the date the Member receives services from the provider.

Eligibility for services may change at any time. Therefore, UPMC Health Plan strongly recommends that all providers verify that the Member is still eligible for behavioral health services at each visit.

A Network provider can also verify that an individual is eligible for behavioral health benefits by accessing **Provider OnLine** at [upmchealthplan.com/providers](http://upmchealthplan.com/providers). Out-of-network providers must call **UPMC Health Plan BHS at 1-866-441-4185**. Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year**.

## Medical Necessity Criteria

At the time of the Member's initial visit, an evaluation of the Member will occur to determine what behavioral health services may meet the Member's needs. However, before providing services, the provider must make sure the services meet medical necessity criteria for that level of care.

UPMC Health Plan BHS uses medical necessity criteria in determining whether to issue a prior authorization for certain types of behavioral health service outlined below.

If the Member's clinical condition necessitates a level of care that is covered in the Member's benefit plan, but that level of care is not available, the next highest covered benefit level of care will be authorized.

The mental health medical necessity criteria currently being utilized by UPMC Health Plan BHS may be obtained as follows:

- *The Mihalik Group's Medical Necessity Manual for Behavioral Health, Version 8.7.0, [themihalikgroup.com](http://themihalikgroup.com)*. For password assistance, call **The Mihalik Group** at **773-929-1722**.

The substance use disorder medical necessity criteria set currently being utilized by UPMC Health Plan BHS may be obtained as follows:

- American Society for Addiction Medicine (ASAM), Patient Placement Criteria (PPC-2R)

**ASAM Publications Distribution Center**  
**PO Box 101**  
**Annapolis Junction, MD 20701-0101**  
**1-800-844-8948**  
**[asam.org](http://asam.org)**

- **NOTE:** This set of criteria is utilized for adults, adolescents, and children.

Contact **UPMC Health Plan BHS** at **1-866-441-4185** to obtain a copy of the medical necessity criteria. Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year**.

## Obtaining Prior Authorizations and Other Utilization Review Activity

If the intended services meet medical necessity (level of care) criteria, reimbursement for the service will occur only if UPMC Health Plan agrees with the determination and has given authorization to provide certain types of behavioral health services. Authorization is an agreement between the provider and UPMC Health Plan that the care planned for a specific Member meets the applicable medical necessity criteria.

To obtain prior authorization for these services, a Network provider must access **Provider OnLine** at [upmchealthplan.com/providers](https://upmchealthplan.com/providers). An out-of-network provider must call **UPMC Health Plan BHS** at **1-866-441-4185** to review medical necessity criteria with a care manager. Care managers are available for providers **24 hours a day, 7 days a week, 365 days a year**. If the request is approved, an authorization number will be generated for a certain time frame and number of units of service. Providers will be given the authorization number at the time of prior authorization.

The summary tables of **Behavioral Health Services** outline applicable medical necessity criteria and which services and UPMC Health Plan products require prior authorization

- See *Behavioral Health Services Requirements Tables L1- L9*, UPMC Health Plan Behavioral Health Services, Chapter L.
- See *Provider OnLine*, in Chapter A - Welcome and Key Contacts, for complete Provider OnLine instructions.



### **Alert – Receiving Prior Authorization**

Receiving prior authorization is not a guarantee that the claim will be paid, as other criteria must be met. Payment is also contingent upon other requirements including, but not limited to, Member eligibility, concurrent review requirements, and focused or retrospective care management reviews.

For certain services requiring prior authorization, additional information must be submitted to UPMC Health Plan BHS care managers before authorization is given. The specific process and documentation requirements will be explained during the prior authorization call with the UPMC Health Plan care manager.

### **Other Utilization Review Activity**

Licensed care managers—under the direction of UPMC Health Plan’s medical director and senior behavioral health care practitioner—review all service authorization requests to determine if they meet medical necessity criteria. Care managers also conduct concurrent (continued-stay) reviews to determine if medical necessity criteria are being met for a continued-stay in the level of care being provided, the need for additional services or supports, or the need for consultation with a UPMC Health Plan peer advisor. Care managers also conduct discharge reviews to determine if the Member is no longer in need of a particular level of care and that appropriate transition planning has occurred.

Services reviewed include, but are not limited to, the following:

- Inpatient services
- Rehabilitation services
- Requests for out-of-network services
- Short-term residential services



### **Alert – Care Management**

Care management staff are not compensated financially, nor is their job performance rated, based upon the number of denials or limits on benefits authorized.

UPMC Health Plan’s utilization management decision-making is based only on appropriateness of care and service and existence of coverage. UPMC Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or service and does not offer financial incentives for utilization management decision-makers.

### **Care Managers May Not Deny Care**

If a Member’s behavioral health status does not meet medical necessity criteria for the level of care requested or if the services do not follow clinical practice guidelines the service is reviewed by a UPMC Health Plan peer advisor who renders a determination of medical necessity.

### **Reviews by Peer Advisors**

UPMC Health Plan contracts board-certified psychiatrists and addiction specialists—some with subspecialty expertise in providing child and adolescent or geriatric care—and licensed psychologists to serve as peer advisors. These professionals are thoroughly trained to evaluate whether proposed services meet medical necessity criteria and follow clinical practice guidelines. Peer advisors perform the following services:

- Render objective decisions on the level of care required (based on medical necessity criteria) and the appropriateness and quality of care
- Advise and consult with UPMC Health Plan’s medical director(s), Medical Management staff, Quality Improvement staff, and other UPMC Health Plan employees as necessary
- Consult with behavioral health providers on prior authorization, concurrent, and post-service reviews

### **Other Clinical Reviews**

Care Management Department staff may conduct other reviews to evaluate utilization of behavioral health services:

- **Focused care management reviews** examine a sample of cases to identify deviations from norms in utilization of a specific service or in access, quality, or cost of the service to determine if new services or reallocation of resources is needed.
- **Retrospective care management reviews** examine the appropriateness or quality of care using indicators such as length of stay or variances from clinical practice guidelines for an individual case or group of cases.



## *Provider Availability Standards*

UPMC Health Plan complies with all applicable provider availability standards (e.g., geographic access standards and ratios of Members to providers). UPMC Health Plan monitors provider availability and access to behavioral health services on an ongoing basis and intervenes as necessary.

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

UPMC Health Plan standards require that Members be given access to covered services in a timely manner. Depending on the urgency of the need for services, these situations are as follows:

- Behavioral health life-threatening emergencies
- Behavioral health non-life-threatening emergencies
- Urgent behavioral health conditions
- Routine outpatient services

### **Behavioral Health Emergencies**

A behavioral health emergency is the sudden onset of a behavioral health condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical or clinical attention could result in seriously jeopardizing or endangering the mental health or physical well-being of the Member or seriously jeopardizing or endangering the physical well-being of a third party. There are two types of behavioral health emergencies:

- A **life-threatening** behavioral health emergency occurs when, as a result of a mental health or substance use disorder, there is reason to believe the Member is (or may become) homicidal or suicidal or the Member or Member's victim may suffer a disabling or permanent physical injury as a result of the Member's behavior or condition. The assessment that a life-threatening emergency exists is based upon statements or behavior, Member self-report, information obtained objectively, or clinical judgment.
  - **NOTE: Care is required immediately for life-threatening emergencies.**
- A **non-life-threatening** behavioral health emergency occurs, when as a result of a mental health or substance use disorder, the Member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within **one hour**.
  - **NOTE: Care is required within one hour for non-life-threatening emergencies.**



### **Alert – Emergency Services**

Emergency services **do not need** prior authorization from UPMC Health Plan.

It is expected that an emergency room, mobile crisis service, or outpatient provider will take immediate action for the safety of the Member and others. They are expected to contact UPMC Health Plan BHS for service authorization as soon as the situation is stabilized. Care Managers are available for providers by calling **1-866-441-4185, 24 hours a day, 7 days a week, 365 days a year.**

If UPMC Health Plan BHS is contacted regarding a Member's need for an emergency service, UPMC Health Plan BHS care managers will:

- Provide a referral to an emergency provider.
- Help arrange emergency transportation.
- Assist with other necessary arrangements to make emergency services available immediately or **within one hour** of the contact.

UPMC Health Plan BHS staff may follow up with the provider to ascertain compliance with this standard for access to emergency behavioral health services.

### **Urgent Behavioral Health Conditions**

Urgent behavioral health conditions of either of the following constitute an urgent situation:

- When, as a result of a mental health or substance use disorder, a Member is experiencing signs, symptoms, or impairment in functioning that would likely require an intensive level of care within **24 hours** if treatment is not provided.
- When a Member expresses a readiness for, or amenability to, treatment if initiated within a **24-hour period.**



#### **Alert – Access to Urgent Care**

Access to care for urgent behavioral health conditions must be provided **within 24 hours.** Urgent care services do not need prior authorization from UPMC Health Plan. However, the provider is required to call UPMC Health Plan at least **one business day** after the date of the admission. Care Managers are available for providers by calling **1-866-441-4185, 24 hours a day, 7 days a week, 365 days a year.**

## Routine Outpatient Services

An outpatient service is considered routine if the Member exhibits signs or symptoms of a mental health or substance use disorder that indicate the need for assessment and/or treatment without evidence of imminent or impending risk to the Member or others or of an acute, significant change in level of functioning.

The Member may directly schedule an appointment with the behavioral health provider, who will use medical necessity criteria to determine the level of service that is needed.



### **Alert – Access to Routine Services**

Access to routine services must be provided within **seven days**.

If the Member contacts UPMC Health Plan directly, a care manager or a health care concierge will help the Member find an available appointment in the required time frame.

If the Member prefers an alternative appointment time that falls beyond the prescribed time frame, the provider should document this (if known) in the provider's appointment records.

As part of UPMC Health Plan's outreach efforts, UPMC Health Plan staff may contact a provider or Member to make arrangements to help Members keep certain appointments (such as follow-up appointments after inpatient care).

## *Coordination of Care, Referrals, and Transition of Care to Other Providers*

Members receive safe, comprehensive health care when all providers of services communicate and work together to educate and encourage Member compliance with treatments and participation in available prevention or disease management programs.

### **UPMC Health Plan’s Expectations for Exchange of Information with Primary Care Physicians and Other Behavioral Health Providers to Facilitate Continuity and Coordination of Care**

Coordination of care with the Member's primary care physician (PCP) or other behavioral health provider is always expected. It is particularly important when the Member is prescribed a medication or treatment that may have an effect on the Member's health or interact with medications or treatments prescribed by the PCP or psychiatrist.

Members for whom coordination of care is especially important include:

- Those with chronic or serious medical illness.
- Those newly prescribed a psychotropic medication who have been taking medication for a medical condition.
- Those requiring multiple medications to treat severe persistent mental health disorders and substance use disorders.
- Those receiving medication who have a history of medication compliance problems.
- Pregnant women who require medication to manage a behavioral health condition.
- Those with a substance use disorder who are prescribed medication for a physical or behavioral health problem, especially when the medication may be habit forming.

To promote communication with the PCP or other behavioral health provider, UPMC Health Plan requires that the provider tell each Member about the importance of involving their PCP or other behavioral health provider in the behavioral health care plan. UPMC Health Plan also expects that the provider will follow up with the PCP or other behavioral health providers and communicate pertinent information as needed. In some circumstances, as outlined by HIPAA regulations, it is important to obtain the Member’s written authorization to communicate certain pertinent information.

Exchange of information with PCPs is monitored from medical record review data on an annual basis. Results will occasionally be shared with providers via the provider newsletter or the UPMC Health Plan website.

## Other Behavioral Health Network Provider Referrals

Referrals to other behavioral health network providers are appropriate when it is determined that a UPMC Health Plan Member requires behavioral health services that are not within the scope of the provider's practice. In these instances, call **UPMC Health Plan BHS** at **1-866-441-4185** and ask an intake coordinator for help in identifying network providers who can provide those services.

Representatives are available **24 hours a day, 7 days a week, 365 days a year**.

Except in an emergency, health maintenance organization (HMO) plan and exclusive provider organization (EPO) plan Members **do not** have out-of-network coverage and may not be referred to a provider outside of the UPMC Health Plan affiliated network without prior authorization from UPMC Health Plan.

Members with a point of service (POS) or a preferred provider organization (PPO) insurance plan should be referred to in-network providers. But these Members may opt to see out-of-network providers with an understanding that they may incur higher out-of-pocket expenses.

## Transition of Care to a Network Behavioral Health Provider

Transition of care to another network behavioral health provider may be necessary when a behavioral health provider is no longer participating in the network(s) affiliated with UPMC Health Plan. When a behavioral health provider contract is voluntarily terminated, a transition period of up to **60 days** may be allowed for Members under the terminated provider's care if the Member was in an ongoing course of treatment at the time of the termination.

- **NOTE:** The transitional period may be extended by UPMC Health Plan if an extension is determined to be clinically appropriate. UPMC Health Plan will consult with the Member and the health care provider in making this determination.
- **NOTE:** The continuation of treatment period for a woman who is in the second or third trimester of pregnancy as of the effective date of coverage, if she is a new Member, or as of the date the notice of termination or pending termination was provided by UPMC Health Plan, shall extend through the completion of postpartum care.
- See *Practitioner and Facility Contracting*, UPMC Health Plan Behavioral Health Services, Chapter L.

## *Referral Assistance Given to Members in Selecting Behavioral Health Providers*

The UPMC Health Plan BHS Health Care Concierge team assists Members who ask for help in identifying a behavioral health provider who meets their needs. Members may request help in identifying potential providers who meet certain selection criteria such as provider location and specialty type. To provide a selection of providers, the Health Care Concierge team will access the provider directory which contains the most current information providers have supplied to Credentialing, Provider Relations, and/or Network Department staff. The Health Care Concierge team may disclose the following information about prospective providers to help the Member select potential providers:

- Name
- Specialty
- Office location, telephone number, and office hours
- Gender (based on credentialing/recredentialing forms completed by the provider)
- Professional credentials, including board certification if applicable
- Hospital and/or practice group affiliation
- Languages spoken by provider/provider staff (based upon the information the provider disclosed on credentialing/recredentialing or assessment/reassessment application forms)
- Capacity to accept new patients

The UPMC Health Plan BHS Health Care Concierge team **may not** disclose providers' malpractice limits and/or history, national practitioner database information, or Drug Enforcement Agency (DEA) number.

The UPMC Health Plan BHS Health Care Concierge team **will not** refer Members to a provider who is not currently accepting new patients nor indicate a preference of one provider over another.

If the Member requires additional assistance in selecting a provider, the call will be referred to a care manager.



### **Alert – Changing Behavioral Health Provider**

Members may ask to change their behavioral health provider at any time.

## *Statement of UPMC Health Plan’s Policy on Incentives*

Utilization management decisions at UPMC Health Plan are based on the appropriateness of care and service for eligible Members and existence of coverage.

Practitioners or other individuals involved in utilization management are not specifically rewarded for issuing denials for coverage of care.

UPMC Health Plan does not offer financial incentives for utilization management decision-makers at any level of the organization that encourage conflicts of interest or decisions that could lead to incidents of underutilization.

## *Clinical Practice Guidelines for Common Behavioral Health Disorders*

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

For information about UPMC Health Plan’s clinical practice guideline adherence measurements, contact **UPMC Health Plan Provider Services** at **1-866-918-1595**, Monday through Friday from 8 a.m. to 5 p.m. and ask to speak to a Quality Improvement staff member.

- See *Clinical and Preventive Health Care Guidelines*, Utilization Management and Medical Management, Chapter G.
- See *Quality Improvement Program*, Utilization Management and Medical Management, Chapter G.



## *UPMC Health Plan Pharmacy Formulary Information*

UPMC Health Plan’s Pharmacy Services Department helps to monitor appropriate utilization and manage health care dollars spent on prescription medications as well as the benefit plans for all lines of business. The department also works with Medical Management to coordinate Member care regarding medications.

For the most current information about the UPMC Health Plan pharmacy formulary and related resources, refer to the UPMC Health Plan website at [upmchealthplan.com](http://upmchealthplan.com).

Click on **Provider**, then select **Other information**, then **Pharmacy resources**.  
[upmchealthplan.com/providers/medical/resources/other/pharmacy.aspx](http://upmchealthplan.com/providers/medical/resources/other/pharmacy.aspx)

- See *Pharmacy Services Chapter*, UPMC Health Plan Provider Manual, Chapter J.

## *Member Rights and Responsibilities*

All Members of UPMC Health Plan have certain rights and responsibilities. Every staff member and behavioral health provider has the obligation and responsibility to know these rights and responsibilities and to support them in daily operations.

Member responsibilities are intended to serve as guidelines to help the Member, provider, and others work cooperatively and effectively for the Member's benefit.



### **Closer Look at Member Rights and Responsibilities**

These guidelines can be found on the UPMC Health Plan website by visiting the following links:

- UPMC *for Kids* (CHIP):  
<https://embed.widencdn.net/pdf/plus/upmc/lhxrfmgqwq/chip-member-rights-responsibilities-web.pdf?u=ogmehe>
  - UPMC *for Life* Complete Care (HMO SNP)  
[https://embed.widencdn.net/pdf/plus/upmc/s7koexdear/2019\\_MEMRGHTRESP\\_19MC-SNP631164-FINAL\\_web.pdf?u=ogmehe](https://embed.widencdn.net/pdf/plus/upmc/s7koexdear/2019_MEMRGHTRESP_19MC-SNP631164-FINAL_web.pdf?u=ogmehe)
  - UPMC *for Life* (Medicare):  
[https://embed.widencdn.net/pdf/plus/upmc/s7koexdear/2019\\_MEMRGHTRESP\\_19MC-SNP631164-FINAL\\_web.pdf?u=ogmehe](https://embed.widencdn.net/pdf/plus/upmc/s7koexdear/2019_MEMRGHTRESP_19MC-SNP631164-FINAL_web.pdf?u=ogmehe)
  - UPMC Health Plan (Commercial):  
[https://p.widencdn.net/jltisx/cm\\_member-rights-responsibilities\\_web](https://p.widencdn.net/jltisx/cm_member-rights-responsibilities_web)
- See *Provider Rights and Responsibilities*, Provider Standards and Procedures, Chapter B.

### **UPMC Health Plan Members Can Ask About Mental Health Advance Directives**

Mental health advance directives are a way for UPMC Health Plan Members (who are **age 18 and older**) to plan for their future mental health care in case they can no longer make mental health care decisions on their own as a result of illness. They can do this by creating a mental health declaration or by appointing a mental health power of attorney or both. A mental health declaration is a set of written instructions that will tell providers:

- What kind of treatment or care the Member prefers.
- Where the Member would like their care to take place.
- The Member's specific instructions about their mental health treatment.

A mental health power of attorney is a document that allows the Member to name a person, in writing, to make mental health care decisions for them if they are unable to make them on their own. Certain criteria must be met to make the document valid (e.g., the Member must be **age 18 or older**, not declared incapacitated by a court, etc.). The mental health power of attorney will make decisions about the Member's mental health care based on the written instructions.

If a UPMC Health Plan Member would like to have a mental health declaration or a mental health power of attorney (or both), they can contact an advocacy organization, such as the **Mental Health Association in Pennsylvania (MHAPA)**. Members should call toll-free **1-866-578-3659** or send an email to **info@mhapa.org**. The MHAPA will provide the necessary forms and answer any questions.

It is important that UPMC Health Plan Members share their written mental health advance directives with their mental health provider. If they do not share their mental health advance directives with their provider, the provider will not be able to follow them.

If the Member or their representative believes that their provider has not handled their mental health advance directives properly, or if they have any other complaints about mental health advance directives, they should follow the standard complaint process.

## *About Being a Behavioral Health Network Provider*

Community Care Behavioral Health Organization (Community Care), an affiliate of UPMC Health Plan, is responsible for contracting and credentialing behavioral health providers for inclusion into the network(s) associated with UPMC Health Plan. Community Care contracts the following types of behavioral health providers to provide behavioral health services to UPMC *for Kids* (CHIP), UPMC *for Life* (Medicare), UPMC *for Life* Complete Care (HMO SNP), and UPMC Health Plan (Commercial) Members:

- **Practitioners** in individual or group practice, including:
  - Psychiatrists.
  - Addictionologists.
  - Developmental-behavioral pediatricians.
  - Doctoral- or master’s-level licensed clinical psychologists.
  - Doctoral- or master’s-level clinical psychiatric nurse specialists.
  - Doctoral- or master’s-level certified registered nurse practitioners.
  - Doctoral- or master’s-level licensed social workers.
  - Other doctoral- or master’s-level licensed behavioral health clinicians.
  
- **Facilities and Organizations:**
  - Clinics
  - Community mental health centers
  - Hospitals
  - Partial hospitalization programs
  - Residential treatment facilities (RTFs)
  - Other organizations providing behavioral health care services in a community setting
  
- **Providers:**
  - Denotes information that applies to both practitioner and facilities.

Behavioral health providers are encouraged to telephone **UPMC Health Plan BHS at 1-866-441-4185**. Representatives are available **24 hours a day, 7 days a week, 365 days a year**.

## Key Points

The following sections provide information about providing quality care to UPMC Health Plan Members, including how to become a contracted behavioral health provider; how to maintain standards for confidentiality, record keeping, and provision of quality care; and other issues affecting behavioral health providers. These sections discuss the following:

- Practitioner credentialing, contracting, and recredentialing
- Facility/Organization assessment, contracting, and reassessment
- Record keeping standards
- Adverse event reporting (to protect patient safety)
- Provider cultural competency
- Provider benchmarking
- Provider satisfaction
- Provider disputes regarding adverse medical necessity determinations
- Provider education
- Provider advisory committee
- New technologies
- Availability of behavioral health case management programs
- Confidentiality and disclosure policies

## Practitioner Credentialing, Contracting, and Recredentialing

For a practitioner (psychiatrist, addictionologist, developmental-behavioral pediatrician, doctoral- or master's-level licensed clinical psychologist, doctoral- or master's-level licensed clinical psychiatric nurse specialist, or doctoral- or master's-level licensed clinical social worker and doctoral- or master's-level licensed behavioral health clinician), credentialing is the first step in UPMC Health Plan's quality improvement process to ensure that Members receive high-quality, responsive, and culturally competent care.

Practitioners who wish to provide services to UPMC Health Plan Members must complete the credentialing process before they are eligible to contract to provide services to UPMC Health Plan Members. The practitioner credentialing process includes evaluations of the practitioner (such as licensing) and the site where services are to be provided.



### Closer Look at Recredentialing

Behavioral Health Practitioners must be re-credentialed every **three years**.

## Practitioner Credentialing Process

Practitioners undergoing initial credentialing or recredentialing who do not require individual discussion by the Community Care Credentialing Committee (commonly referred to as "clean files") are those who:

- Meet eligibility requirements without exception.
- Have provided all requested information.
- Have no discrepancies between the information they provided, and the information received from verification sources.

The chief medical officer or designated physician representative of Community Care has the authority to determine that the provider file is "clean." The chief medical officer or designee signs off indicating that the file is complete, clean, and approved. This signoff date is used as the formal approval date. All other practitioners for initial credentialing or recredentialing who require individual discussion by the Credentialing Committee are credentialed on the date the Credentialing Committee reviews the candidate's completed application and approves it.

## Key Points

The practitioner credentialing process involves three major steps:

- Each credential (degrees, certifications, and licenses) is verified by Community Care's Credentialing Department with primary sources (academic institution, certifying body, licensing board or agency, etc.).
- The completed application, which includes all credentials verified with primary sources, site visit(s) if necessary, and review of treatment record keeping practices completed satisfactorily if necessary, must be reviewed and approved **within 180 days of the date the application was signed**. If not, the application must be refreshed with Community Care by returning a copy of the original application with a new attestation that the practitioner reviewed for any changes or additions. This application must be returned to Community Care with a newly signed and dated attestation.
- All criteria must be met and verified to consider the application complete for credentialing.



### **Alert – Department of Human Service Provider Enrollment**

All providers who render, order, refer or prescribe items or services to Pennsylvania CHIP Members are required to have a valid PROMISe ID (also known as MMIS Provider ID) with the Commonwealth of Pennsylvania. The provider must obtain an ID for each location at which they provide services to CHIP Members. If the provider participates with multiple CHIP managed care organizations, the provider is only required to enroll once per service location. If a claim is denied due to the lack of a PROMISe ID, the provider may **NOT** hold the CHIP Member liable.

➤ See *Provider Enrollment*, UPMC for Kids (CHIP) Chapter D.

Practitioners have the following rights during the credentialing process:

- The right to review information submitted to support their credentialing application
- The right to correct any erroneous information after the application has been submitted by contacting the credentialing supervisor within **30 days** of submission
- The right to be informed of the status of their credentialing application upon request

These rights can be initiated verbally or in writing by contacting the **Community Care credentialing supervisor** at **1-888-251-2224** or by sending a fax to **412-454-2174**. Send written requests to:

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

### **Change in Practitioner Information**

Any change to information submitted by a behavioral health practitioner during the credentialing and contracting process, or at any time, thereafter, including information such as street and suite address and telephone and facsimile numbers, must be communicated to Community Care's Provider Relations Department.

To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to UPMC Health Plan Members, practitioners are asked to call **UPMC Health Plan BHS** to speak with their **Community Care provider relations representative** at **1-888-251-2224** with any change to practitioner information at least **30 days** prior to making any such changes. Representatives are **available 24 hours a day, 7 days a week, 365 days a year**.

Community Care will send **Practitioner Attachment A form** to be completed and returned so that all applicable departments can be notified of the change.



### **Closer Look at Adding or Changing a Service or Site**

If a practitioner change involves **adding** or **changing** a contracted service or a site where services are provided to UPMC Health Plan Members, the addition or change must meet recredentialing standards **before** payment for services can be processed.

- **NOTE:** Contracts are service location specific, so services provided to UPMC Health Plan Members may only be rendered at those locations where the provider holds a current contract.

## Practitioner Contracting

A behavioral health practitioner may begin the contracting process after the practitioner completes the credentialing process with Community Care. Community Care seeks to contract with specific practitioners to provide specific behavioral health services at specific sites.

Criteria considered for contracting include:

- The service needs of prospective UPMC Health Plan Members.
- The geographic and demographic distributions of UPMC Health Plan Members.
- The geographic distribution and cultural competencies of UPMC Health Plan BHS' practitioners.
- Each behavioral health practitioner's scope of services, capacity to serve UPMC Health Plan Members, and responsiveness to quality issues.

Fee schedules are developed based on need, available resources, and market demands. Rates for alternative services not listed on the fee schedule may be negotiated.

When necessary to meet anticipated or actual Member needs or payer requirements, Community Care's Network Development staff will work with Community Care's Credentialing Department and UPMC Health Plan BHS to identify specialized services.

If the behavioral health practitioner's contract is terminated, affected UPMC Health Plan Members may be allowed up to **60 days** to continue to be cared for by that particular behavioral health practitioner unless the contract was discontinued as a result of a professional review action, refusal of the practitioner to continue to treat the Member, or else the practitioner is no longer willing to accept the agreed upon terms or payment.

- **NOTE:** The transitional period may be extended by UPMC Health Plan if an extension is determined to be clinically appropriate. UPMC Health Plan will consult with the Member and the practitioner in making this determination.
- **NOTE:** The continuation of treatment period for a woman who is in the second or third trimester of pregnancy as of the effective date of coverage, if she is a new Member, or as of the date the notice of termination or pending termination was provided by UPMC Health Plan, shall extend through the completion of postpartum care.

## Practitioner Recredentialing

Behavioral health practitioners must be recredentialled **three years** from the date of initial credentialing or last recredentialing date. Community Care's provider relations representatives will notify behavioral health practitioners in advance when it is time to start the recredentialing process, which is similar to the credentialing process with the additional consideration of quality information supplied by the Quality Improvement Department.



An application for recredentialing is considered complete when it includes the following:

- Primary source verification of the practitioner’s credentials (any new degrees or certifications, etc., since the time of the last credentialing or recredentialing date, verification of current licensures, malpractice and claims history, etc.)
- Practitioner performance monitoring, including analyses of Member complaints, adverse event reports, provider benchmarking issues, and quality and/or compliance audit results

### **All Practitioners Must Be Recredentialed Before Their Expiration Date.**

Failure to be re-credentialed before the expiration date will result in termination of the practitioner’s contract with Community Care and will prevent payment for any services provided after the expiration date. It is the practitioner’s responsibility to ensure that Community Care has the most accurate and current address by which to contact them to begin the recredentialing process.

A behavioral health practitioner whose credentials with Community Care have expired cannot be authorized or paid for services provided after the expiration date.



#### **Alert – Verifying Credentials**

Because verifying credentials with primary sources requires time to complete, Community Care’s Credentialing Department sends applications for recredentialing before each practitioner’s deadline.

Practitioners are urged to start the recredentialing process as soon as the application is received. Community Care’s Provider Relations representatives will periodically remind practitioners of application components that remain incomplete. However, completing the recredentialing process remains the practitioner’s responsibility.

Behavioral health practitioners have the following rights during the recredentialing process:

- The right to review information submitted to support their recredentialing application.
- The right to correct any erroneous information after the application has been submitted by contacting the credentialing supervisor within **30 days** after submission.
- The right to be informed of the status of the recredentialing application upon request.

Any of the rights above can be initiated verbally or in writing by contacting the credentialing supervisor. Call Community Care and ask to speak with the **credentialing supervisor** at **1-888-251-2224** or send a fax to **412-454-2174**. Send written requests to:

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

## **Regarding Files of Provider Information Maintained at Community Care Behavioral Health**

- Physical files are maintained in a locked room or locked file cabinet when not being used by Credentialing staff or the Credentialing Committee.
- Provider files stored in electronic, magnetic, or optical format are protected with individualized login credentials.
- Access to provider files is limited to Credentialing Department staff, the Credentialing Committee, Network Management staff, and the Compliance staff.
- Upon request, practitioners may review information in their file, except for any information from the National Practitioner Data Bank (NPDB). Review of NPDB information is prohibited by federal statute.
- Providers are informed of the right to review information in their file through the cover letter in the application packages for credentialing/recredentialing or assessment/reassessment.
- Providers may obtain a copy of their file by making the request in writing. Credentialing staff will send a copy of the provider’s file—marked “confidential”—to the provider within **10 business days** of receipt of the written request for the file. NPDB information and peer review (peer reviewer) information is not included in the file sent to the practitioner.

Written requests should be submitted to:

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

Providers are notified by credentialing staff of any information obtained during credentialing/recredentialing or assessment/reassessment activities that varies substantially from the information provided by the provider.

Providers have the right to correct erroneous information by submitting corrections in writing or sending additional documents to the Credentialing Department. Credentialing staff will document in the file any verbal information or corrections provided by the provider. The credentialing staff member who obtained the information will date and sign the file.

## *Facility/Organization Assessment, Contracting, and Reassessment*

Assessment of a facility (clinic, community mental health center, hospital, partial hospitalization program, residential treatment facility (RTF), or any other organization providing behavioral health care services in a community setting) is the first step in UPMC Health Plan’s quality improvement process to promote high-quality, responsive, and culturally competent care. A facility must complete this process in order to be eligible to contract to provide behavioral health services to UPMC Health Plan Members. Assessment includes evaluations of the facility (such as licensing) and the site where services are to be provided.



### **Closer Look at reassessment**

A facility must be reassessed every **three years**.

### **Facility/Organization Assessment**

A facility is considered to have completed its assessment on the date the credentialing supervisor and chief medical officer or designee of Community Care reviews the organization’s completed application, verifies that all criteria have been met and signs the facility assessment form.

#### **The facility assessment process involves four major steps:**

- Credentialing staff confirms the facility’s licensure and facility’s accreditation, if any, and status or standing of the facility with state regulatory bodies.
- In lieu of Community Care doing a site visit, Community Care will accept the facility’s current Centers for Medicare & Medicaid Services (CMS) or state review report and any corrective action related to the review.
- Each location where the facility will offer behavioral health services to UPMC Health Plan Members must pass a site visit unless the facility has a current accreditation by The Joint Commission, Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA). If, after assessment, a facility adds a location where behavioral health services are to be provided and the new location has not been reviewed, a site visit may be conducted on this new location, unless a copy of the facility’s current CMS or state review report and any corrective action related to the review is received or verification that this site is included in the accreditation.

Trained professionals employed by Community Care conduct the site visit. Before the site visit is scheduled, the facility will be given a copy of the non-accredited facility on-site review form which lists the criteria for assessing and reassessing a site, such as presence of fire extinguishers, ADA-accessible restroom, and policies and procedures in place covering topics such as emergency care, cultural awareness, and diversity competence.

Included in the site visit is the review of treatment record keeping practices using the medical record review form, which is performed to assess the adequacy of documentation/record-keeping procedures. Documentation must pass the review of treatment record-keeping practices, which may include review of a blinded or mockup treatment record.

A copy of this form will be provided to the facility prior to the site visit, facilities are notified in writing if the score for the on-site review and medical record review is below passing. When the score is below passing, the facility must submit a written corrective action plan within **10 business days** of receiving the notification.

- The completed application (with all primary source verification completed, site visit(s) and treatment record-keeping practices completed satisfactorily, if applicable) must be reviewed and approved **within 180 days** of the date the application was signed. To verify that data accurately reflects current facility information, Community Care maintains the **180-day** standard to complete this process. In the event that this process shall **exceed 180 days**, the facility will be sent a copy of the original application and will be required to sign a new attestation to confirm that the data is currently accurate or will need to revise the information on the original application.

All facility criteria must be verified to consider the application for assessment complete. Primary source verification is performed by Community Care’s Credentialing Department.

Facilities have the following rights during the assessment process:

- The right to review information submitted to support their application
- The right to correct any erroneous information after the application has been submitted by contacting the credentialing supervisor within **30 days** after submission
- The right to be informed of the status of their application upon request

Any of the rights above can be initiated verbally or in writing by contacting the credentialing supervisor. Call **Community Care** and ask to speak with the **credentialing supervisor** at **1-888-251-2224** or send a **fax** to **412-454-2174**. Send written requests to:

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

## Change in Facility Information

Any change to information submitted by the facility during the assessment and contracting process or any time thereafter, including information such as mailing address and telephone and fax numbers, must be communicated to Community Care's Provider Relations Department.

To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to UPMC Health Plan Members, facilities are asked to call their **Community Care provider relations representative** at **1-888-251-2224** with **any change** to facility information at least **30 days** prior to making any such changes. Representatives are available **24 hours a day, 7 days a week**. If necessary, Community Care will send a facility Attachment A form to be completed and returned so that all applicable departments can be notified of the change.



### Alert – Facility Changes

If the facility change involves **adding** or **changing** a service or a site where services are provided to UPMC Health Plan Members, the addition or change must be reviewed and a site visit may be required, **before** payment for services can be processed.

## Facility Contracting

A facility may begin the contracting process after the facility completes assessment by Community Care. Community Care seeks to contract with facilities to provide specific behavioral health services in specific geographic locations.

Criteria considered for contracting include:

- The service needs of prospective UPMC Health Plan Members.
- The geographic and demographic distributions of UPMC Health Plan Members.
- The geographic distribution and cultural competencies of facilities.
- Each facility's scope of services, capacity to serve Members, and responsiveness to quality issues.

Fee schedules are developed based on need, available resources, and market demands. Rates for alternative services may be negotiated.

When necessary to meet anticipated or actual Member needs or payer requirements, Community Care's Network Development staff will work with the Credentialing and UPMC Health Plan BHS Departments to identify facilities that provide specialized services.

For any facility terminated from the network, up to a **60-day** transition of care period—for routine ambulatory services only—may be initiated for UPMC Health Plan Members under that facility's care.

## Facility Reassessment

Facilities must be reassessed **three years** from the date of initial assessment or of the last reassessment.

The Community Care Network Department will notify facilities in advance when it is time to start the reassessment process, which is similar to the assessment process with the additional consideration of quality information supplied by the Quality Improvement Department. An application for facility reassessment is considered complete when:

- Credentialing staff confirms any new licensures, facility accreditation and certifications, etc., since the date of the last assessment/reassessment, verification of current licensures, etc.
- Facility performance is monitored, including analyses of Member complaints, adverse event reports, and quality and/or compliance audit results.

### All Facilities Must Be Reassessed Before Their Expiration Date

Failure to be reassessed before the expiration date will result in termination of the facility's contract with Community Care and will prevent payment for any services provided after the expiration date.

It is the facility's responsibility to ensure that Community Care has the most accurate and current contact information by which to contact them to begin the recredentialing process.

A facility whose assessment with Community Care has expired cannot be authorized or paid for services provided after the expiration date.



### Alert – Verifying Credentials

Because verifying credentials with primary sources requires **time to complete**, Community Care's Network Department sends applications for reassessment before each facility's deadline.

Facilities are urged to start the reassessment process as soon as the application is received. A Community Care provider relations representative will remind facilities periodically of application components that remain incomplete. However, completing the reassessment process remains the responsibility of those operating the facility.

Facilities have the following rights during the reassessment process:

- The right to review information submitted to support their application
- The right to correct any erroneous information after the application has been submitted by contacting the credentialing supervisor within **30 days** of submission
- The right to be informed of the status of their application upon request

Any of the rights above can be initiated verbally or in writing by contacting the credentialing supervisor. Call **Community Care** and ask to speak with the credentialing supervisor at **1-888-251-2224** or send a fax to **412-454-2174**. Send written requests to:

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

## *Termination of Provider from the Behavioral Health Network*

A provider may be terminated from the UPMC Health Plan BHS Network with or without cause.

### **Termination Without Cause**

The provider agreement may be terminated **without cause** by either party at any time upon **90 days** prior written notice to the other party. Such notice shall clearly state the effective date of such termination. All terms and provisions of this agreement shall remain in effect until the effective date of termination except as otherwise noted.

### **Termination with Cause**

Action to terminate a behavioral health provider immediately **with cause** may be initiated when Community Care becomes aware of any of the following:

- The provider is excluded or suspended from participation in a government funded health care program, including, but not limited to Medicare, Medical Assistance (Medicaid), CHIP, or CHAMPUS/TRICARE
- Failure of the provider to meet the credentialing or recredentialing standards of Community Care
- Any indictment, arrest or conviction for a felony or any other criminal charge of the provider related to the provision of health care services to individuals regardless of membership with Community Care
- A final disciplinary action against the provider by a licensing or regulatory authority
- A final determination by any applicable licensing or regulatory authority that the health, safety, or well-being of any Member is being endangered or jeopardized by continuation of this agreement
- A determination by Community Care and/or UPMC Health Plan that immediate termination of the provider is in the best interests of UPMC Health Plan Members
- Action taken under this Section shall include, but not be limited to, substandard medical care or any other activity determined by Community Care or UPMC Health Plan to not be in the best interest of UPMC Health Plan Members
- Material breach of the provider agreement
- Loss or suspension of accreditation, if required
- Loss of required insurance



- Failure by the provider to abide by all the terms and conditions of the applicable Quality Improvement and UPMC Health Plan BHS Programs as determined by Community Care in its sole discretion
- Provider is adjudged bankrupt, becomes insolvent, has a receiver of assets or property appointed, makes a general assignment for the benefits of creditors, or institutes or causes to be instituted any procedure for reorganization or rearrangement of provider's affairs
- If applicable, the provider's medical staff privileges at any facility are suspended, revoked, terminated or voluntarily relinquished in lieu of disciplinary action

## **Notification and Process to Appeal Adverse Determinations Regarding Network Participation**

Behavioral health providers are notified of any determination affecting their continued participation in the Behavioral Health Provider Network in writing, via certified mail, including credentialing/recredentialing or assessment/reassessment, suspension of new referrals, or termination from the network. This written notification will include the reason for the decision and an explanation of the appeal process, if any. Termination without cause by Community Care is not subject to appeal.

### **The appeal process, if applicable, is as follows:**

- Within **30 days** of the date of the notification, the provider must send a letter, fax, or email to the Community Care chief medical officer (CMO) **to request to appeal the decision.**
- The CMO will schedule an appeal committee meeting to be held within **30 days** of receiving the provider's request.
- The provider will be informed of the date, time, and place of the meeting and of the provider's right to be present at the hearing, to be represented by an attorney or anyone else of their choosing, to present relevant information, and to request a different date and time of hearing should the provider be unable to attend the hearing as scheduled.
- UPMC Health Plan will be informed of the provider's request to appeal the action and the right of UPMC Health Plan to be present at the hearing, to be represented by an attorney, to present relevant information, and to request a different date and time of hearing should UPMC Health Plan be unable to attend the hearing as scheduled.
- The provider will receive written notification of the appeal committee's decision within **two business days** of the date of the decision.
- The decision of the appeal committee is final.

## *Record Keeping Standards*

Community Care has established treatment record documentation guidelines, performance goals, and standards for availability of treatment records to facilitate accurate record keeping, communication between providers, and coordination and continuity of care within the behavioral health continuum and medical delivery system.

### **Each Member’s medical record must meet the following standards:**

- The patient address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, authorization forms and guardianship information are documented, as relevant.
- The patient's name and an identification number are present on each page.
- The responsible clinician's name and professional degree are documented.
- All entries are dated.
- The record is legible.
- Relevant medical conditions are listed, prominently identified, and updated.
- Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- Special status situations such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented, and updated in compliance with written protocols.
- Past medical and psychiatric history is documented, including previous treatment dates, provider information, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests and consultation reports.
- Allergies and adverse reactions are clearly documented.
- Assessment for co-occurring disorders.
- Documentation of continuity and coordination of care efforts between behavioral practitioners and the PCP as well as with other behavioral health providers.
- Medication(s) that have been prescribed, dosages of each medication, and the dates of initial prescription and of any changes in medication regimen, if applicable.
- Diagnostic information is documented.
- Complete developmental history is documented for children and adolescents.
- The following are documented:
  - Symptoms
  - Mental status at each session
  - Patient strengths and limitations
  - Compliance with treatment plan
  - Compliance with medication regimen, if appropriate
  - Progress towards treatment goals
  - Coordination of care information, as applicable
  - Date of next session
  - Discharge plan

**The following elements are required components of an organized record keeping system:**

- A unique treatment record for each patient
- Treatment record notes maintained in chronological or reverse chronological order
- An organized system for maintaining documents for each patient.  
For example, all diagnostic reports are maintained together in one section of the folder
- An organized filing system that provides easy access to unique patient files
- Consent to release information and informed consent documentation as appropriate
- Treatment record documentation occurs as soon as possible after the encounter with special status situations, such as imminent harm, suicidal ideation, or elopement potential prominently noted



**Alert – Record Keeping Expectations**

Community Care and UPMC Health Plan expect providers and facilities to:

- Implement these treatment record documentation guidelines to remain in good standing in the network.
- Maintain an organized treatment record keeping system.
- Provide treatment to Members in a safe environment.

All medical records and reports completed by the provider for UPMC Health Plan Members are to be available, as appropriate and with required Member consent, to other providers treating the Member, Community Care, UPMC Health Plan, CMS, The Department of Human Services (DHS), National Committee for Quality Assurance (NCQA), State Department of Health (DOH), licensing body, or regulatory agency, or other agencies as required by applicable law and regulations, for at least **10 years** after the initial date the provider delivered health care services to the Member under contractual agreement with Community Care, regardless of termination of the contractual agreement.

The review of treatment record keeping practices, using a medical record review form, is one component of the provider’s site visit. Facilities that do not provide a copy of their state licensing report or who are not accredited by The Joint Commission, Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA) must meet the record keeping standards established by Community Care. Record keeping must also meet all licensing regulations. The provider is sent the medical record review form instrument prior to the scheduled site visit.

The provider may prepare for the medical record review by designating an actual treatment record for review, preparing a blinded treatment record, or preparing a mock treatment record for review.

The purpose of the credentialing medical record review is to ensure that the provider has resources in place to collect the information needed through all stages of evaluation and treatment. Providers are notified in writing if the score is below passing. When the score is below passing, the provider must submit a written corrective action plan within **10 business days** of receiving the notification. A follow-up medical record review may be scheduled within **six months** to monitor implementation of the provider's corrective action plan.

In addition, the completeness of treatment records may also be assessed by using one or more of the following methods:

- Reviewing a sample of treatment records on-site at the behavioral health provider's office
- Obtaining a sample of treatment records from providers by mail-in or fax to Community Care or UPMC Health Plan
- Reviewing treatment records sent to Community Care or UPMC Health Plan for other reasons

➤ **NOTE:** The performance goal for completeness of treatment record documentation is **86 percent**.

### **Adverse Event Reporting (to Protect Patient Safety)**

To promote care delivered in a safe environment and based upon clinically appropriate assessment and interventions, behavioral health providers are to identify and report adverse events involving UPMC Health Plan Members.

#### **Adverse events include, but are not limited to:**

- Completed suicides.
- Apparent homicide or serious physical assault by a Member.
- Member injury due to restraint/seclusion.
- Life-threatening injury or illness while on provider site requiring hospitalization.
- Sexual/physical abuse complaint by Member against provider.
- Elopement from a psychiatric facility.
- Incident reports that a UPMC Health Plan Member admitted to a psychiatric facility is missing for more than **24 hours**.
- Any fire requiring evacuation of the Member while Member is hospitalized.
- Severe adverse effects of psychotropic medications or interactions requiring hospitalization or emergency care.

**Behavioral health providers must report Adverse Events as soon as reasonably possible but no later than within two business days of the incident** by calling UPMC Health Plan BHS at **1-866-441-4185** or faxing the incident report to the **Quality Improvement Department** at **1-412-454-6240**. Representatives are available **24 hours a day, 7 days a week, 365 days a year**. Providers are also expected to comply with all applicable state and federal laws and professional and legal requirements regarding reporting of adverse events.

Providers should report all cases of suspected child or elder abuse that involve a UPMC Health Plan Member to the appropriate agency as defined by law. UPMC Health Plan's Quality Improvement Department will analyze adverse events for contributing delivery of care patterns, to identify opportunities for improvement, and to monitor the effectiveness of changes. Member safety issues and adverse event reports will be reviewed to determine if any steps need to be taken to resolve a care practice that contributed to the adverse event(s). Reports regarding adverse events are also reviewed at the time of recredentialing/reassessment.

UPMC Health Plan expects all providers and facilities to provide treatment to UPMC Health Plan Members in a safe environment. All behavioral health providers should assess a Member for suicidal and homicidal ideation throughout the Member's treatment. If a Member is being treated in an outpatient setting and expresses suicidal or homicidal ideation, the provider should take the appropriate actions to safeguard the Member and/or others, such as facilitating an inpatient hospitalization admission.

Upon admission for an inpatient psychiatric hospitalization, the initial evaluation completed by the facility psychiatrist should clearly document that the Member was assessed for both suicidal and homicidal ideation. Members being treated in an inpatient setting should be assessed for suicidal and homicidal ideation on an ongoing basis to protect the Member's safety, as well as the safety of others. Providers should also proceed with a duty to warn if indicated.

When a Member is discharged from an inpatient hospitalization stay, a crisis plan should be developed by the facility and reviewed with the Member upon discharge. The crisis plan should also include the phone number of the appropriate county services for mental health emergencies.

## *Provider Cultural Competency*

To promote an effective and accessible system of behavioral health care, providers need to be culturally competent. To enhance cultural competency of network providers, Community Care:

- Assesses providers' cultural competency.
- Presents a training session for providers in principles of cultural competence.
- Develops outcomes measures related to the care provided in a culturally diverse system.

Assessment of cultural competency includes evaluation of the diversity of providers in the behavioral health network and their documented experience in delivering culturally competent behavioral health care.

UPMC Health Plan also evaluates Member informational materials, including audio-visual materials, training documents, service pamphlets and radio or television public service announcements to assess if the material is appropriate to meet the cultural needs of its Members.

Providers' cultural competency will be evaluated using instruments and methods that are consistent with cultural patterns and norms of the Members being served. The instruments used will vary according to the specific cultural groups being surveyed. However, all instruments used will evaluate whether the provider understands the culture of the community being served and uses strategies to avoid breakdowns and pitfalls due to cultural insensitivity in the provision of care.

During a credentialing site visit, the provider is required to produce a written policy or policy statement regarding cultural diversity, awareness, and competence. Failure to have a written policy or policy statement results in a request for corrective action, which is required for the provider to pass the site visit standards.

The Quality Improvement Department will review all complaints received related to cultural competency of providers, conduct trend analyses, and determine appropriate follow-up when needed. Providers' commitment is essential to the ongoing development of a responsive system of care.

## *Provider Performance Tracking*

Provider performance tracking is the process of collecting, analyzing, monitoring, and reporting information about the activity and quality of the behavioral health provider network.

Measures are chosen and developed in conjunction with behavioral health providers so that the indicators are meaningful to providers and can be impacted through their quality improvement efforts.

- See *Provider Performance Tracking*, Utilization Management and Medical Management, Chapter G.

## *Provider Satisfaction*

Community Care and UPMC Health Plan welcome comments from providers concerning the services received from UPMC Health Plan staff and on how those services can be improved. Provider satisfaction surveys are regularly distributed to a random sample of network behavioral health providers to obtain provider feedback. If received, providers are asked to complete and return the survey, as UPMC Health Plan values provider feedback.

If a provider is dissatisfied with any aspect of Community Care’s or UPMC Health Plan’s operations, concerns can be expressed by calling **UPMC Health Plan BHS** at **1-866-441-4185**. Representatives are available **24 hours a day, 7 days a week, 365 days a year**.

If an issue cannot be resolved informally, a formal complaint can be submitted either orally or in writing. Written complaints should be submitted as follows:

**For provider complaints regarding credentialing or contracting matters (including network participation or fee schedules):**

**Community Care Behavioral Health  
Credentialing Department  
Suite 1300  
339 Sixth Ave.  
Pittsburgh, PA 15222**

**For all other provider complaints:**

**UPMC Health Plan  
Complaints & Grievances Department  
PO Box 2939  
Pittsburgh, PA 15230-2939**

If the complaint cannot be resolved immediately, a resolution letter will be sent to the provider within **30 days**.



## *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.

- See *Provider Disputes*, Provider Standards and Procedures, Chapter B.

## *Provider Education*

Provider training sessions on a variety of topics are available through Community Care. These sessions focus on developing skills in managing care, meeting and exceeding performance standards, and ensuring cultural competence in delivery of behavioral health care services. Call **Community Care's Provider Relations** at **1-888-251-2224** or visit the Community Care website at **cbh.com** for information about these training sessions.

## *Provider Advisory Committee*

Behavioral health network providers are eligible, welcome, and encouraged to participate in the Community Care Provider Advisory Committee. The committee holds a meeting quarterly to address business issues and concerns raised by committee members and behavioral health providers.

In addition, the Provider Advisory Committee nominates one provider representative bi-annually to serve as the provider co-chair of the Provider Advisory Committee.

Other opportunities exist to join other Community Care and UPMC Health Plan committees that include behavioral health providers. Call **UPMC Health Plan BHS** at **1-866-441-4185** for information about participating on the committee. Representatives are available **24 hours a day, 7 days a week**.

## *New Technology*

UPMC Health Plan has a policy to review proposed new treatments for behavioral health disorders. To submit a new technology request for review, first discuss the request with a UPMC Health Plan BHS care manager. The care manager will forward the request to a UPMC Health Plan medical officer for review and consideration by the UPMC Health Plan Technology Assessment Committee.

UPMC Health Plan provides for a systematic assessment of new technologies and new applications of existing technologies for behavioral health care, including clinical interventions, procedures, devices, and certain types of pharmacological treatments. UPMC Health Plan's Technology Assessment Committee meets on a routine basis to consider new technologies proposed for inclusion in its benefits packages.

## *Case Management Programs*

### **Availability of Behavioral Health Case Management Programs**

UPMC Health Plan offers **seven** behavioral health case management programs for **Commercial** and **Medicare** Members:

- A **depression program** for Members who have been newly started on an antidepressant and have been diagnosed with depression.
- An **attention deficit hyperactivity disorder (ADHD) program** for children diagnosed with ADHD who have been newly started on a stimulant medication. Family Members are welcome to participate in the ADHD program.
- An **anxiety program** for Members who are newly diagnosed with anxiety or have been consistently on anti-anxiety medications.
- A **substance use disorder program** for Members that have been admitted to inpatient detox or rehab or for Members struggling with substance use disorder issues.
- An **outreach program** for Members recently discharged from inpatient behavioral health treatment and for any other Members with behavioral health case management needs.
- A **pain management program** explores the mind and body connection between pain and behavioral health. Helping Members understand how their thoughts, attitudes and beliefs about pain directly impact their experience with pain.
- A **grief program** was developed to provide grief education and support to Members. Grief is a natural reaction to losing someone close to you and it affects everyone. Grief can weaken one's immune system, make underlying depression worse, and interfere with effective management of other health conditions.

**Commercial** and **Medicare** Members can access information and resources by calling the **Behavioral Health Case Management Services** toll-free at **1-888-777-8754 (TTY: 711)** to request information. **Representatives are available 24 hours a day, 7 days a week.**

The programs are available at no cost to UPMC Health Plan **Commercial** and **Medicare** Members and materials for the programs are designed to supplement information Members receive about diagnosis and treatment from their providers. To obtain more information about these programs, call **UPMC Behavioral Health Case Management Services** at **1-888-777-8754 (TTY: 711)**.

UPMC *for Kids* (CHIP) Members can access information, resources, and request information by calling **UPMC Health Plan Care Management** at **1-866-778-6073 (TTY 711)**, Monday through Friday, 7 a.m. to 8 p.m. and Saturday 8 a.m. to 3 p.m.

➤ See *UPMC for Kids (CHIP), Chapter D*, for information about available programs.

## **Confidentiality and Disclosure Policies**

All providers are required to have appropriate policies in place concerning the confidentiality of Member information.

The confidentiality policies must meet requirements of the Health Insurance Portability and Accountability Act (HIPAA), applicable state laws and regulations, and any applicable agreement with UPMC Health Plan or Community Care.

Behavioral health network providers are responsible for maintaining confidentiality in the collection, use, and disclosure of Member-identifiable information.

## *Quality Improvement Overview*

The quality of health care that UPMC Health Plan Members receive is very important. At UPMC Health Plan, considerable resources are dedicated to improving the health care experience of Members. UPMC Health Plan’s quality improvement program is overseen by a Quality Improvement Committee made up of clinicians—including behavioral health specialists—dedicated to improving quality of care and service to Members.

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

### **Member Satisfaction**

Member satisfaction is one of UPMC Health Plan’s highest priorities. It is annually assessed to better meet the needs of our Members.

Information from the behavioral health Member satisfaction survey is regularly used by UPMC Health Plan’s Quality Improvement Team to develop a more comprehensive plan for improving and maintaining Member satisfaction.

Results from Member satisfaction surveys have led to initiatives to streamline UPMC Health Plan operations, improve customer service, and collaborate and communicate more effectively with network providers about health care delivery and the experience our Members want and need.

### **Information About Member Complaint and Grievance Procedures**

Members who are dissatisfied with the services they receive from UPMC Health Plan or from their providers may file a complaint. In addition, Members have the right to appeal any decision regarding payment or the failure to approve, furnish, arrange for, or continue what the Member believes are covered services.

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

Federal Employees Health Benefits Program (FEHB)	<a href="http://upmchealthplan.com/fehb">upmchealthplan.com/fehb</a>
UPMC <i>for Kids</i> (CHIP) UPMC <i>for Life</i> (Medicare) UPMC <i>for Life</i> Complete Care (HMO SNP)	<a href="http://upmchealthplan.com">upmchealthplan.com</a>
UPMC Health Plan (Commercial)	<a href="https://p.widencdn.net/39a2gm/19CG-IND792767-2020-Welcome-Guide_PQ">https://p.widencdn.net/39a2gm/19CG-IND792767-2020-Welcome-Guide_PQ</a>

- See the following *UPMC Health Plan Provider Manual chapters* for Member Complaints and Grievances Procedures.

Chapter C	UPMC Health Plan (Commercial)
Chapter D	UPMC <i>for Kids</i> (CHIP)
Chapter F	UPMC <i>for Life</i> (Medicare)
Chapter M	UPMC <i>for Life</i> Complete Care (HMO SNP)

## *Fraud and Abuse Reporting*

UPMC Health Plan investigates suspected fraud and abuse as defined as follows:

### **Fraud**

Health care insurance fraud is defined as the submission by a health care provider or Member of false or knowingly inaccurate or deceptive information to a health insurance carrier or vendor (or one of their providers) for the purposes of obtaining reimbursement or provision of services for which the recipient of said reimbursement or services is not entitled. This definition shall also include any health insurance carrier employee who knowingly aids, abets, or colludes with providers or Members in their receiving reimbursement or services to which they are not entitled. Examples of fraud include:

- A provider submitting a bill for a service that did not occur.
- Billing for a time period greater than the time actually spent with the Member.
- Billing for provision of a service that did not meet the service definitions.

### **Abuse**

Abuse by a provider would be defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to UPMC Health Plan or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. "Abuse" also includes Member practices that result in unnecessary costs to UPMC Health Plan. Examples of abuse include:

- Providers billing for unnecessary or excessive services.
- Providers performing a laboratory test on a large number of patients when the provider knows only a few should have it.

Any UPMC Health Plan staff member suspecting fraud must report the suspicion to his or her supervisor or directly to UPMC Health Plan's Special Investigations Unit (SIU). If the supervisor is notified first, he or she must report the suspicion to the SIU **within one business day** of receiving the staff member's report. The SIU then investigates per UPMC Health Plan policy.

When fraud or abuse is confirmed, UPMC Health Plan reports the fraud or abuse to the appropriate licensing, reporting, and investigative agencies and takes appropriate action to prevent future fraud or abuse. Consequences of confirmed fraud include, at least, repayment of money paid for the fraudulent claims and the requirement to submit a plan of corrective action to prevent reoccurrence. Suspension, exclusion from the behavioral health network of providers, and levying of a fine are additional possibilities. Further, notification to appropriate licensing, reporting, and investigative agencies will take place.

## **Provider Actions to Avoid Fraud and Abuse**

UPMC Health Plan encourages behavioral health providers to read the UPMC Health Plan Provider Manual and/or call **UPMC Health Plan BHS** at **1-866-441-4185** with any questions about standards of care, documentation and record keeping, claims/billing procedures, or any other activity that could be associated with a fraud or abuse concern. Representatives are available **24 hours a day, 7 days a week**.

UPMC Health Plan behavioral health providers contracted through Community Care may contact their **Community Care provider relations representative** at **1-888-251-2224** or the UPMC Health Plan SIU for additional resources related to fraud, waste, and abuse compliance.

For any concern or issue regarding fraud or abuse, UPMC Health Plan maintains a fraud and abuse hotline number which can be contacted at any time. The **UPMC Health Plan Fraud and Abuse Hotline number** is **1-866-FRAUD-01**.

# *UPMC Health Plan Claims Procedures*

UPMC Health Plan pledges to provide accurate and efficient claims processing. To make this possible, UPMC Health Plan requests that providers submit claims promptly and include all necessary data elements.

A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims.

➤ *See **Claims Procedures**, UPMC Health Plan Provider Manual, Chapter H.*

Contact the **UPMC Health Plan Provider Services Department** at **1-866-918-1595** with any questions regarding claims.

Contact the **UPMC Health Plan Claims Department** at **1-888-876-2756** for questions regarding Electronic Data Interchange.