UPMC Community HealthChoices (Medical Assistance)

At a Glance

UPMC Community HealthChoices of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in the Commonwealth of Pennsylvania. Eligible recipients are those who are **21 years old and older** and are eligible for Long-Term Services and Supports (LTSS) or are eligible for both Medical Assistance and Medicare. UPMC Community HealthChoices, as one of three state-wide Managed Care Organizations (MCO) for the Commonwealth's Community HealthChoices (CHC) program, offers coverage for medical care and Long-term Services and Supports (LTSS) to its Members (also called "Participants"). UPMC Community HealthChoices includes a vast network of medical and home and community-based service providers.

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

Alert—Department of Human Services Regulations

This manual may not reflect the most recent changes to the Department of Human Services regulations. The Provider Manual is updated at least annually, or more often, as needed to reflect any program or policy changes made by the Department of Human Services (DHS) via Medical Assistance bulletins when such changes affect information that is required to be included in the Provider Manual. These updates will be made within **six months** of the effective date of the change(s), or within **six months** of the issuance of the Medical Assistance bulletin, whichever is later. Issues requiring mass communication are included in the monthly ***Provider Partner Update*** (PPU) newsletter.

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

Provider issues identified by Provider Services or the Quality Improvement Department are addressed on a case-by-case basis depending on the nature of the issue. If resolution is not achieved during the provider's initial contact, the appropriate internal department is engaged and follow-up with the provider occurs after the issue has been resolved. Issues requiring mass communication are included in the monthly ***Provider Partner Update*** (PPU) newsletter.

Community HealthChoices Managed Care in Pennsylvania

UPMC Community HealthChoices provides at least the same level of service coverage offered by Pennsylvania's Medical Assistance Adult Benefit Package and §1915(c) Home and Community Based waiver programs.

Behavioral health coverage is provided by behavioral health managed care organizations (BH-MCOs) that contract with DHS and operate at the county level.

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

Population Served

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

- Receive Medicare and Medical Assistance (dual eligible), or
- Receive Medical Assistance and LTSS because their level of care makes them nursing facility eligible.

Individuals are not eligible for Community HealthChoices if they are:

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

Closer Look at the Community HealthChoices population

Participants eligible for LTSS:

- Participants may reside in a long-term nursing facility or in the community.
- Participants have access to services and supports not generally covered by traditional Medicare or Medical Assistance physical health coverage.

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

Participants dual eligible for Medicare and Medical Assistance:

- Participants have two distinct plans—a Medicare plan and a Community HealthChoices (Medical Assistance) plan.
  - Participants may choose UPMC Community HealthChoices as their Medical Assistance plan but choose another insurer for their Medicare coverage that is not UPMC Health Plan.
  - Participants may choose UPMC Community HealthChoices as their Medical Assistance Plan and choose UPMC Health Plan for their Medicare coverage [UPMC *for Life* Complete Care (HMO SNP) or UPMC *for Life* Medicare (Advantage Plan)].

Participants eligible for Medical Assistance/LTSS only:

- Physical health providers must be in UPMC Community HealthChoices' network to provide services to Participant's eligible for Medical Assistance/LTSS only (UPMC Community HealthChoices is primary coverage).

  - See ***Covered Benefits***, UPMC Community HealthChoices (Medical Assistance), Chapter N.

- **NOTE:** Physical health providers do not need to be in UPMC Community HealthChoices' network to provide Medicare-covered services to dual eligible Participants. Medicare providers can continue to see their patients and receive Medicare reimbursement.

  - See ***Coordination between Medicare and UPMC Community HealthChoices,*** (Medical Assistance), Chapter N.

Coordination Between Medicare and UPMC Community HealthChoices

For Participants who are dual eligible, Medicare is the primary payer and UPMC Community HealthChoices is the secondary payer. Participants can choose any Medicare provider or plan. UPMC Community HealthChoices works with all Medicare providers and plans to coordinate services. When providing Medicare-covered services, Medicare providers do not need to be in UPMC Community HealthChoices' network. After Medicare pays first, UPMC Community HealthChoices will decide if it needs to pay the provider secondary.

➢ *See **Medical Assistance Revalidation Requirement***, Provider Standards and Procedures, Chapter B.

If there is a Medicare copayment, coinsurance or a deductible due from the Participant, that amount is included in the coordination of benefits calculation.

- If the Medicare payment is greater than the UPMC Community HealthChoices fee schedule payment, the provider must accept the Medicare payment as payment in full. The participant would not be responsible for the amounts applied to a copayment, coinsurance or deductible by their Medicare plan.

- If the Medicare payment is less than the UPMC Community HealthChoices fee schedule, UPMC Community HealthChoices will coordinate benefits and pay up to the UPMC Community HealthChoices fee schedule amount. The provider is required to accept the payment as payment in full. The Participant would not be liable for any copayment, coinsurance, or deductible applied by their Medicare plan.

- UPMC Community HealthChoices **does not pay** copayments or cost-sharing for Medicare Part D prescriptions.

Covered Benefits

At a Glance

UPMC Community HealthChoices network providers provide a variety of medical and LTSS services, some of which are itemized on the following pages. For specific information not covered in this manual, call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday. UPMC Community HealthChoices includes, but is not limited to, coverage provided by the DHS Medical Assistance Adult Benefit Package and § 1915(c) Home and Community Based waiver programs.

Table N1: UPMC Community HealthChoices Covered Physical Health Services*
Abortions (Limited)**
Ambulance Transportation
Ambulatory Surgical Center (ASC) Services
Certified Registered Nurse Practitioner Services
Chiropractic Services
Clinic Services/Independent Clinic
Dental Services (including dentures with limits)
Diagnostic, Screening, Preventive, and Rehabilitative Services (including Tobacco Cessation)
Durable Medical Equipment (DME)
Emergency Room
Family Planning (Clinic Services and Supplies)
Federally Qualified Health Center
Home Health Services (including Nursing, Aide, and Therapy)
Hospice Care
Inpatient Hospital Services (Acute and Rehab)
Laboratory
Maternity (Physician, Certified Nurse Midwives, Birth Centers)
Medical Supplies
Nonemergency Medical Transport (Limited)
Nursing Facility Services
Optometrist services and eyeglasses for certain medical conditions prescribed by a physician skilled in the treatment of disease of the eye or by an optometrist
Outpatient Hospital Clinic Services
Physical Therapy, Occupational Therapy and Services for Individuals with Speech, Hearing, and Language Disorders
Physician Services and Medical and Surgical Services provided by a Dentist
Podiatrist Services

Table N1: UPMC Community HealthChoices Covered Physical Health Services (cont'd.)
Prescribed Drugs
Prescribed prosthetic devices
Primary Care Services
Radiology (X- rays, MRIs, CTs)
Renal Dialysis Services
Rural Health Clinic
Short Procedure Unit (Outpatient Hospital)
Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of DHS
**An Abortion is a covered service only when a physician has found, and certified in writing to the Medicaid agency that, on the basis of that physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term (which is in accordance with 42 CFR 441.202).
Definitions for Physical Health Services may be found in the Pennsylvania Medicaid State Plan at: **dhs.state.pa.us/publications/medicaidstateplan/**

Table N2: UPMC Community HealthChoices Covered LTSS Benefits*
Nursing Facility Services
Nursing Facility Services are professionally supervised nursing care and related medical and other health services furnished by a health care facility licensed by the Pennsylvania Department of Health as a long-term care nursing facility under Chapter 8 of the Healthcare Facilities Act (35 P.S. §§ 448.801-448.821) and certified as a nursing facility provider in the MA Program (other than a facility owned or operated by the Federal or State government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services, but which are needed and provided on a regular basis in the context of a planned program or health care and management. A Participant must be nursing facility clinically eligible (NFCE) to receive nursing facility services as a LTSS benefit. Nursing Facility Services includes at least the items and services specified in 42 C.F.R. § 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 Pa. Code § 1187.51.
Exceptional DME for Community HealthChoices Participants Residing in a Nursing Facility Exceptional DME is covered in a Nursing Facility outside of the Nursing Facility Per Diem per Exceptional DME Medical Bulletin **[33 Pa.B. 5256].** Exceptional DME in the Nursing Facility must be obtained by a UPMC Health Plan participating DME provider. The participating DME provider will submit authorization requests as needed and submit for reimbursement per standard claims processing. The **place of Service** for Exceptional DME should **be 32 (Nursing Facility).** Exceptional DME services will follow current UPMC Health Plan policy and procedures and authorization requirements as applicable.

Table N3: UPMC Community HealthChoices Covered Home and Community-Based Services *	
Adult Daily Living	Non-Medical Transportation
Assistive Technology	Nursing
Behavior Therapy	Nutritional Counseling
Benefits Counseling	Occupational Therapy
Career Assessment	Participant-Directed Community Supports
Cognitive Rehabilitation	Participant-Directed Goods and Services
Community Integration	Personal Assistance Services
Community Transition Services	Personal Emergency Response System
Counseling	Pest Eradication
Employment Skills Development	Physical Therapy
Financial Management Services	Residential Habilitation
Home Adaptations	Respite
Home Delivered Meals	Specialized Medical Equipment and Supplies
Home Health Aide	Speech and Language Therapy
Job Coaching	Structured Day Habilitation
Job Finding	Telecare
	Vehicle Modifications

- **NOTE:** Some services are included on the UPMC Community HealthChoices Covered Physical Health Services list and the UPMC Community HealthChoices LTSS Benefits list. The UPMC Community HealthChoices LTSS Benefits are available **only after** the Participant's Medicare or private insurance and UPMC Community HealthChoices Physical Health coverage limitations have been reached, or if the service is not covered by Medicare, private insurance, or UPMC Community HealthChoices Physical Health coverage.

*Definitions for the LTSS services listed above can be found in the 1915(c) Home and Community Based Services Waiver, as may be amended from time to time, found at: **healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264258.pdf**

To learn more about LTSS covered services, contact **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

Key Points

UPMC Community HealthChoices covers medically necessary services included in the DHS Medical Assistance Adult Benefit Package and 1915(c) Home and Community Based Services Waiver program.

UPMC Community HealthChoices Participants who are dual eligible for Medicare and Medical Assistance should receive Medicare-covered services from Medicare providers in their Medicare plan's network. Medicare is the primary payer. UPMC Community HealthChoices only pays primary for covered services if the service is not covered by Medicare or Medicare benefits have been exhausted. In these cases, the provider must be in the UPMC Community HealthChoices provider network.

Coordinated Care

The Participant's primary care provider (PCP) must coordinate care. If a Participant has Medicare, Medicare-covered care should be coordinated with providers in the Participant's Medicare network.

When coordinating care under UPMC Community HealthChoices, if the PCP refers a Participant to a network specialist and indicates a need for diagnostic testing, the Participant should be directed to a network facility for that testing. A separate referral by the specialist is not required.

When needed, Participants can seek a second opinion from a qualified provider within the network, at no cost to the Participant. If a qualified Provider is not available within the network, the Participant will receive assistance in obtaining a second opinion from a qualified provider outside the network, at no cost to the Participant, unless copayments apply.

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

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

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

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

A provider may bill a UPMC Community HealthChoices Participant for a noncovered service or item only if, before performing the service, the provider informs the Participant of the following:

- The nature of the service;
- That the service is not covered by UPMC Community HealthChoices and UPMC Community HealthChoices will not pay for the service; and
- The estimated cost to the Participant for the noncovered service.

The provider must document in the medical record that the Participant was advised of his or her financial responsibility for the service and has agreed to accept financial responsibility for the service.

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

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

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

  - See additional ***Appointment Standards*** in the charts below.

  - **NOTE:** The following information is provided to the Participants in the Participant Handbook.

New Participants

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

Ob-gyn and PCPs

Emergency	Must be seen **immediately** or referred to an emergency
Urgent medical conditions	Must be scheduled within **24 hours** of request.
Routine care	Must be scheduled within **10 business days** of request
Wellness (physical, wellness exam, well-child exam)	Must be scheduled within **three weeks** of request
Well-woman exams	Must be scheduled within **three weeks** of request
Maternity care	Initial prenatal care appointments must be scheduled: • First trimester – within **10 business days** of request • Second trimester – within **five business days** of request • Third trimester – within **four business days** of request High-risk pregnancies – within **24 hours** of notifying the provider of the high risk, or immediately, if an emergency exists

Ob-gyn and PCPs (cont'd.)

Nonurgent Sick Visits	Within **72 hours** of request
If Participant reports to ER but does not require or receive care for symptoms	**Promptly**

Your PCP and ob-gyn must be available to you **24 hours a day**, **seven days a week**, **365 days a year**. They may have an answering service or paging system that will contact them after their office has closed. Leave a phone number where the PCP or ob-gyn can call you back.

Specialists

Emergency cases	Must be seen **immediately** or referred to an emergency room
Urgent medical conditions	Must be scheduled within **24 hours** of request
Routine care	Must be scheduled within **15 business days** of request for the following specialty providers: Dentist Dermatology Orthopedic Surgery Otolaryngology Must be scheduled within **10 business days of request for all other** specialty providers.

Service Descriptions

This section includes important information about frequently used services. For more information about these or other covered services, contact **Provider Services** at **1-844-860-9303.**

Behavioral Health and Substance Use Disorder Benefits

UPMC Community HealthChoices **does NOT** manage the Participants' behavioral health benefits. Behavioral health and substance use disorder treatment is available through coordination with the Participant's Behavioral Health Managed Care Organizations (BH-MCOs). These services include care for those with behavioral health needs, substance use disorder needs, and those with dual behavioral health diagnoses (behavioral health and substance use disorder diagnoses).

Commonly available services include **24-hour care and rehabilitation for treatment of substance use** disorder in a hospital or nonhospital setting, services for detoxification from alcohol or other drugs, outpatient services for substance use disorder treatment, peer-delivered support services, and crisis services as needed. Also included are medication-assisted treatment for substance use disorders, for example methadone maintenance or suboxone treatment.

Commonly available **Behavioral Health treatment** services include outpatient therapy and psychiatry, partial day programs, inpatient hospitalization, and community-based services such as mobile psychiatric rehab and targeted case management among others.

To refer for behavioral health and substance use disorder treatment, providers can directly contact the BH-MCO in the Participant's county. Upon referral, the BH-MCO will coordinate appropriate appointments and/or treatment plans with providers based on specific behavioral health and substance use disorder treatment needs and conditions. If behavioral health and substance use disorder needs exceed standard benefit coverage, Participants with LTSS benefits may be eligible for additional benefits. Providers should contact the **Service Coordination department** when coordinating care for Participants with LTSS.

Service Coordination Department	
Southwest Pennsylvania	**1-844-860-9302**
Southeast Pennsylvania	**1-833-672-8078**
Remainder of Pennsylvania	**1-833-280-8508**

➢ See ***Table A2: UPMC Community HealthChoices (Medical Assistance Contacts) for a list of BH-MCOs***, Welcome and Key Contacts, Chapter A.

Chiropractic Care

UPMC Community HealthChoices Participants may self-direct to chiropractic care. Chiropractic services are covered when medically necessary and delivered by a network provider. Certain chiropractic codes are not on the Medical Assistance fee schedule. Coverage for procedures not on the Medical Assistance fee schedule may only be requested as a Program Exception under the Program Exception process.

> ➢ **NOTE:** UPMC Community HealthChoices **will not** cover x-rays when performed by a chiropractor; however, chiropractors may refer Participants to a network provider for x-rays.

Dental Care

SKYGEN USA administers routine dental benefits, including prior authorization medical necessity reviews for UPMC Community HealthChoices Participants. Participants may self-direct their dental care to a network provider.

- Providers may contact the **SKYGEN USA Provider Call Center** directly at **1-855-806-5193 (TTY: 711)** or **providerservices@skygenusa.com.**
- Participants may call the UPMC Community HealthChoices Health Care Concierge team at **1-844-833-0523 (TTY: 711).**

> ➢ See the ***SKYGEN USA Dental Provider Manual*** for full details of the dental prior authorization process at **skygenusa.com**.

Dental Services

UPMC Community HealthChoices Participants have access to dental services as noted in **Table N4: Dental Limits**.

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

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

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

> ➢ See ***Program Exception Process***, UPMC Community HealthChoices (Medical Assistance), Chapter N.

Dental Limits

Dental benefits and limits for UPMC Community HealthChoices Participants are outlined in Table N4.

> ➢ **NOTE**: There are differences in benefits/limits for participants who are eligible for Home and Community Based Services (HCBS) or residing in a nursing facility and participants who are neither eligible for HCBS nor living in a nursing facility.

Table N4: Dental Limits		
Description	**Full Benefits**	
	***NOT RESIDING** in a Nursing Facility and not eligible for HCBS*	***RESIDING** in a Nursing Facility or eligible for HCBS*
Anesthesia	**Covered** May require prior authorization	**Covered** May require prior authorization
Checkups *-Routine exam, including X-rays*	**Covered - 1 per 180 days** Additional exam requires a BLE	**Covered**
Cleanings *-Prophylaxis*	**Covered - 1 per 180 days** Additional cleanings requires a BLE	**Covered**
Crowns and adjunctive services	**Not Covered** Unless a BLE is approved	**Covered** Requires prior authorization
***Dentures** *-One partial upper denture or one full upper denture and one partial lower denture or one full lower denture.*	**Covered – Once per lifetime** Requires prior authorization Additional dentures require a BLE	**Covered - Once per lifetime** Requires prior authorization Additional dentures require a BLE
Dental surgical procedures	**Covered** Requires prior authorization	**Covered** Requires prior authorization
Dental emergencies *-Emergency care*	**Covered**	**Covered**
Extractions *-Impacted tooth removal*	**Covered** Requires prior authorization	**Covered** Requires prior authorization
Extractions *-Simple tooth removal*	**Covered**	**Covered**
Fillings *-Restorations*	**Covered**	**Covered**
****Orthodontics** *-Braces*	**Not Covered**	**Covered** Requires prior authorization
Palliative care *-Emergency treatment of dental pain*	**Covered**	**Covered**
Periodontal & endodontic services	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
Root canals	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
X-rays	**Covered**	**Covered**
***Inpatient hospital, Short Procedure Unit (SPU), or Ambulatory Surgical Center (ASC) dental care**	**Covered** Requires prior authorization	**Covered** Requires prior authorization

*If Medical Assistance paid for a partial or full upper denture since April 27, 2015, the Participant can only receive another partial or full upper denture if they qualify for a BLE. If Medical Assistance paid for a partial or full lower denture since April 27, 2015, the Participant can only receive another partial or full lower denture if they qualify for a BLE.

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

***Medically necessary dental care such as:

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

Diagnostic Services

These services include laboratory services, x-rays, and special diagnostic tests. They are covered when ordered by a network provider and performed by a network ancillary provider.

Refer to the Participant's behavioral health managed care organization for coverage of diagnostic services related to behavioral health and substance use disorder.

- See ***Behavioral Health and Substance Use Disorder Benefits***, UPMC Community HealthChoices (Medical Assistance), Chapter N.
- See ***UPMC Community HealthChoices Behavioral Health Services – Table A2***, Welcome and Key Contacts, Chapter A.

Closer Look at Laboratory Services

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

There are several different types of CLIA certifications:

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

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are required to submit their CLIA certificates even though they are paid an all-inclusive per encounter payment rate that includes laboratory tests provided at the time of a face-to-face visit.

Hospital laboratories are to be Medicare certified or certified by the Pennsylvania Department of Health (DOH) as meeting the standards comparable to those of Medicare.

Out-of-state hospitals do not need to be licensed by DOH but must have current Medicare certification.

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

  dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/p_033918.pdf

  dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/p_033919.pdf

Emergency Care

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

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

Closer Look at Emergency Care

The hospital or facility must contact the **Utilization Management** Department through **Provider Online** at **upmchealthplan.com/providers** and submitting a prior authorization request within **48 hours or on the next business day** following an emergency admission that resulted in an inpatient hospital admission.

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

Redirected Emergency Department Visit

If a Participant is instructed by their PCP to come into the office, but instead goes directly to the emergency department and does not have an emergency medical condition, the visit may be considered a redirected emergency department visit. Such visits are subject to review on a case-by-case basis to determine the appropriate level of reimbursement.

Alert - Redirected Emergency Department Visit

Within 24 hours of redirecting an emergency department visit, the PCP must **c**ontact the Participant with any alternative care arrangements, such as an office visit or treatment instructions.

Hearing Exams/Aids

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

Home Health Care

Home health care services are covered when coordinated through a network provider. The following services may require prior authorization after a standard number of visits have been exhausted:

- Home health aides
- Home infusion therapy
- Medical social services
- Occupational therapy
- Physical therapy
- Registered dietitian services
- Skilled/Intermittent nursing
- Speech therapy

The provider must contact **Utilization Management** for a prior authorization review of medical necessity to receive coverage of home health aide services in the home. Providers must request prior authorization by submitting a completed UPMC Health Plan medical necessity form, a Letter of Medical Necessity and all relevant clinical and social information through **Provider OnLine** at **upmchealthplan.com/providers.** Medical necessity forms and instructions for submitting authorization requests can be found at **upmchealthplan.com/providers/forms.** Failure to obtain authorization will result in denial of the claim. If written information is required, it may be sent to:

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

If Home Health Care needs exceed standard benefit coverage, Participants who are eligible for LTSS may qualify to receive additional home health care benefits.

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

Home Medical Equipment (HME)

Home medical equipment (e.g., hospital beds, manual wheelchairs, walkers, or respiratory equipment including oxygen therapy) is covered when coordinated through a network provider and used for medically necessary services that are on the Medical Assistance fee schedule.

Specialized Home Medical Equipment (SHME)

Some specialized home medical equipment, including but not limited to power mobility devices (e.g., power wheelchairs and scooters), pressure reducing support surfaces, lymphedema pumps, and bone growth stimulators, require a prior authorization review. SHME is covered when coordinated through a network provider and used for medically necessary services that are on the Medical Assistance fee schedule.

The provider must contact **Utilization Management** for a prior authorization review of medical necessity to receive coverage of certain SHME as indicated in the online policies and procedures manual found at **upmchealthplan.com/providers.** Providers must submit a prior authorization through **Provider OnLine** by accessing **upmchealthplan.com/providers.** Failure to obtain authorization will result in denial of the claim. If Specialized Home Medical equipment needs exceed standard benefit coverage, Participants who are eligible for LTSS may qualify to receive additional medical equipment benefits.

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

Home Physician Visits

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

Hospice Care

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

Hospital Admissions

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

If the admission is an Emergency admission the hospital or facility must contact the **Utilization Management Department** through **Provider OnLine** by accessing u**pmchealthplan.com/providers** and entering the authorization request within **48 hours** or on the **next business day** following an emergency that resulted in the inpatient hospital admission.

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

Immunizations

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

Nursing Facility Services

If a UPMC Community HealthChoices participant enters a Nursing Facility (NF) for a skilled nursing stay, UPMC Community HealthChoices covers the first 30 days of care via the participant's physical health benefit (after any applicable Medicare benefits have been exhausted). If the skilled nursing stay turns into long-term care and the participant is eligible for long-term services and supports (LTSS), UPMC Community HealthChoices will continue to cover the stay via the participant's LTSS benefit.

It is the NF's responsibility to assist the individual through the eligibility process for LTSS, if they are not already eligible.

> ➢ See **DHS Bulletin #03-18-20, Changes to Managed Care Coverage of Nursing Facility Services** for more information at: **.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/c_283001.pdf**

UPMC Community HealthChoices follows the following guidelines for reimbursement of services:

- Bedhold Days:
  - NF must be at 85 percent occupancy per DHS published quarterly reports. Bed hold occupancy qualifications will be based on quarter results.
  - If the criteria above is met, UPMC Community HealthChoices will reimburse the NF:
    - **1/3 of the then current per diem rate.**
    - A maximum of **15 Bedhold Days** per hospitalization

- Therapeutic Days:
  - Cover up to **30 days per calendar year.**

- Hospice Days
  - NF will be reimbursed for Hospice Days.
  - The Hospice provider will be reimbursed for Hospice Services Directly.

Continuity of Care

If the NF leaves the network and a Participant is not eligible to receive an extended continuity of care period, the Participant may continue to receive NF services, if eligible, from the NF for **up to 60 days** from the dates described below, whichever occurs last:

- The date the Participant is notified by UPMC Community HealthChoices of the termination or pending termination of the provider or

- The date of the provider termination

Continuity of Care does not apply for a NF provider termed from the UPMC Community HealthChoices network for Cause per provider's UPMC Health Plan Ancillary Agreement.

UPMC Community HealthChoices participants admitted to a Nursing Facility after the Eligibility Start Date for UPMC Community HealthChoices. not under the continuity of care period outlined above, will receive the continuity care period as described below:

NF resident moves from HealthChoices (HC) to UPMC Community HealthChoices

- HC-MCO will pay for up to **30 days**
- HC-MCO will pay for **day 31 through the date the eligibility determination** is made that member is eligible for NF services.
- UPMC Community HealthChoices will pay **beginning the day after** resident is found eligible to receive NF services.

NF resident moves from Fee-for-Service (FFS) to UPMC Community HealthChoices

If the resident is determined eligible to receive NF services:

- FFS will pay for the retroactive period.
- FFS will pay from date of application to the date eligibility is determined.
- UPMC Community HealthChoices will pay beginning the day after eligibility is determined.

Community HealthChoices Nursing Facility Ineligible (NFI) dual*

- UPMC Community HealthChoices will pay for **up to 30 days** (including hospital reserve bed days and therapeutic leave days).

- Once the NFI participant is found eligible for long-term care services, the NF can bill UPMC Community HealthChoices for providing services **beyond 30 days**.

- UPMC Community HealthChoices shall not pay for services that a participant is not eligible to receive.

*NFs are required to request authorization for services for all new **30-Day** Skilled Nursing Facility stay for UPMC Community HealthChoices Nursing Facility Ineligible (NFI) participants.

Prior authorization requests are submitted through **Provider OnLine** at **upmchealthplan.com/providers.**

- See ***Provider OnLine***, Welcome and Key Contacts, Chapter A.
- See ***How to Contact or Notify Utilization Management***, Utilization Management and Medical Management, Chapter G.

Office Visits

PCP visits are covered. Specialist visits are covered with a PCP referral and coordination.

Closer Look at Referrals

UPMC Community HealthChoices **does not require the submission of paper referral forms.** PCPs may refer a Participant to a network specialist following standard medical referral practices such as calling the specialist or by providing the Participant a "script" or letter for the specialist's records. The PCP and specialist should coordinate care. The PCP and specialist must contact **Utilization Management** for prior authorization approval of an out-of-network referral by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers.**

- **NOTE:** Out-of-network Indian Tribe, Tribal Organization, or Urban Indian Organization Health Care Providers (I/T/U HCPs) can refer Indian Participants (as defined by 42 CFR § 438.14(a)) to in-network providers.

Organ Transplants

Certain organ transplants are covered but require prior authorization from UPMC Community HealthChoices. Participants must receive a referral from their PCP for specialist and diagnostic workups.

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

Routine care performed by out-of-network providers is not covered for UPMC Community HealthChoices Participants.

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

Medically necessary nonemergency services provided by an out-of-area or out-of-network provider may be covered if:

- It is unreasonable to expect the Participant to return to the UPMC Community HealthChoices service area for treatment and prior authorization is obtained.
- The Participant experiences an urgent condition that requires immediate attention and for which a delay in care would result in a significant decline in the Participant's health.
- Medically necessary services are not available in the UPMC Community HealthChoices provider network and a prior authorization is obtained.

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

A medical director will review the prior authorization request for medical necessity. The provider will be notified of the determination by phone. If the request is denied, the provider and Participant will receive written notification. The provider can appeal a denial by following the instructions outlined in the denial letter.

Participants who receive LTSS may be eligible to receive out-of-area LTSS services when traveling. The Provider or Participant should contact the **Service Coordination Department for prior authorization.**

Service Coordination Department	
Southwest Pennsylvania	**1-844-860-9302**
Southeast Pennsylvania	**1-833-672-8078**
Remainder of Pennsylvania	**1-833-280-8508**

Alert – Out-of-Network Care Referrals

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

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

Alert -Out-of-Area Services

Emergency and routine care provided outside the United States is **NOT covered.** The Affordable Care Act of 2010 prohibits payments to institutions or entities located outside the United States. United States is defined to include the District of Columbia, Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Outpatient Surgery

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

Podiatric Care
Medically necessary podiatric care is covered with a referral from the Participant's PCP.

Prescription Drug Coverage
UPMC Community HealthChoices provides drug coverage for participants. Limits and prior authorizations may apply. UPMC Community HealthChoices participants who are dual eligible with Medicare and Medical Assistance should be prescribed drugs on their Medicare plan formulary.

➢ See ***UPMC Community HealthChoices Pharmacy Program***, Pharmacy Services, Chapter J.

Prosthetics and Orthotics
Prosthetic and orthotic services must be coordinated through a network provider.

Prosthetic and orthotic items on the Medical Assistance fee schedule are covered when medically necessary. Some items require prior authorization.

Prosthetic and orthotic repairs and replacements require prior authorization for coverage.

Rehabilitative Therapy

Inpatient
Inpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the Participant's PCP and delivered by a network provider. The therapy must be medically necessary and prior authorization must be obtained. The prognosis must indicate the potential for improvement.

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

If rehabilitative needs exceed standard benefit coverage, Participants who are eligible for LTSS may qualify to receive additional therapy benefits.

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

Reproductive Procedures

Abortion

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

An abortion is covered when a physician certifies that due to a condition, illness, or injury, an abortion is necessary to prevent the death of the woman, which is a medical judgment to be made by the certifying physician. A licensed physician may make the certification whether or not the physician has a pecuniary or proprietary interest in the abortion.

An abortion is covered for women who are victims of rape or of incest if:

- The rape victim makes a report to a law enforcement agency or public health service agency within **72 hours** of the rape.
- The incest victim makes a report to a law enforcement agency or public health service agency within **72 hours** of the time her physician informs her that she is pregnant.

The notification must occur before the abortion is performed.

The physician must complete a **Physician Certification for an Abortion Form (MA-3 or MA-3s)**. This form must be maintained in the Participant's medical record and a copy submitted with the claim.

Closer Look at Cases of Rape and Incest

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

- Was a victim of rape or incest.
- Reported the incident, including the identity of the offender, if known, to the appropriate law enforcement agency. The statement must include the name of the agency as well as the date the report was made.
- Is aware that any false statements and/or false reports to law enforcement authorities are punishable by law.

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

Hysterectomy

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

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

Tubal Ligation

A tubal ligation is covered when coordinated through a PCP or ob-gyn provider and performed by a network provider. The Participant must voluntarily give informed consent to the procedure. The Participant also must sign a **Sterilization Consent form (MA-31 or MA-31s)** at least **30 days**, but no more than **180 days**, before the procedure to receive coverage. The consent form must be maintained in the Participant's medical record and a copy of the form must be submitted with the claim.

Vasectomy

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

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

Closer Look at Abortion, Hysterectomy, Tubal Ligation, and Vasectomy

Prior authorization is not required when an Abortion, Hysterectomy, Tubal Ligation, or Vasectomy are performed in-network. But if the Member requires an inpatient admission, following the procedure, Providers must request prior authorization for the admission through **Provider OnLine** by logging on at **upmchealthplan.com/providers.**

Specialist Care

Coverage is provided for specialty care when performed by a network provider with a referral from the PCP. Coverage is only for those services coordinated by the PCP. To ensure coverage, specialists must refer the Participant to network providers for laboratory testing and X-rays. Any additional services must be referred and coordinated through the PCP.

Out-of-network services and/or any care ordered by an out-of-network provider are not covered unless specifically approved by UPMC Community HealthChoices. The out-of-network provider must obtain prior authorization by contacting **Utilization Management** at **1-844-849-2926.**

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

Transportation

Emergency Transportation (Ambulance)
Participants do not need prior authorization for emergency transportation related to emergency medical conditions.

> ➢ **NOTE:** Certain Air Ambulance codes are not covered under the UPMC Community HealthChoices fee schedule, but may be considered for coverage when an authorization is requested through the Program Exception process. The Program exception authorization request must be requested through **Provider OnLine** by logging on at **upmchealthplan.com/providers.**

Nonemergency Transportation (Non-Routine)
All requests for medically necessary Medical Assistance covered nonemergency transportation (limited services, as defined in the UPMC Health Plan Non-Emergent Ambulance Transportation Policy and Procedure at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx#N**), must be coordinated through **UPMC Medical Transportation** at **1-877-521-RIDE (7433)** for the following:

- Air ambulance (requires program exception approval)
- Ground ambulance or
- Other rides as defined in the UPMC Health Plan Non-Emergent Ambulance Transportation Policy

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

If the Participant needs assistance scheduling medical transportation, the **UPMC Community HealthChoices Health Care Concierge team** can be reached **24 hours a day** by calling **1-844-833-0523 (TTY: 711).** UPMC Community HealthChoices Participants with LTSS have Service Coordinators who can also assist Participants to sign up and schedule rides with MATP. For more information about medical transportation, contact **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

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

Urgent Care

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

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

Closer Look at Urgent Care

If the Participant is unable to call the PCP before going to the emergency department and the Participant does not have an emergency medical condition, the emergency department should attempt to contact the PCP for approval before providing services. If the PCP does not respond within **30 minutes** or cannot be reached, the emergency department or Participant should attempt to contact **Provider Services** at **1-844-860-9303**. If the emergency department cannot reach UPMC Community HealthChoices it should provide the service and attempt to contact the PCP or UPMC Community HealthChoices afterward.

Vision Benefits (Routine)

Routine Vision benefits are administered by **Envolve Vision.** Benefit coverage may vary. Providers may direct routine vision benefit questions to **Envolve Vision** directly at 1**-866-838-7612.**

Participants receive:

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

Women's Health

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

Ob-gyn Services (Non-routine)
Participants with women's health problems may self-direct care to a network ob-gyn.

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

UPMC Community HealthChoices Participants may access, at a minimum, the education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, long acting reversible contraceptives (LARC) such as intrauterine devices (IUDs) and subdermal contraceptive implants, diaphragms, foams, creams, jellies, condoms (male and female), injectables, and other family planning procedures.

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

UPMC Community HealthChoices offers pregnant women the UPMC Health Plan Maternity Program, which provides patient centered support and education throughout the prenatal and postpartum period.

Maternity health coaches provide education either by telephone or in-home visits and coordination of care with an emphasis on the psychosocial and socioeconomic issues that could affect a pregnancy. They are available to answer Participants' questions, provide education and remove barriers to care.

Closer Look at Health Coaches
A health coach is a health care professional who specializes in the delivery of a wide spectrum of lifestyle programs for improving nutrition, increasing physical activity, quitting smoking or other tobacco use, managing weight, and more. They also deliver programs designed to help individuals better manage chronic health conditions such as diabetes, coronary artery disease, hypertension, asthma, and depression.

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

Post-partum Care

The post-partum period is an extremely important time for the well-being of both the mother and baby. UPMC Community HealthChoices supports the proactive scheduling of the post-partum office visit **between seven** and **84 day**s after the baby's birth. Additionally, UPMC Community pays for post-partum home health visits for UPMC Community HealthChoices participants.

Obstetrical Needs Assessment Form (OBNA)

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

Providers should complete the OBNA form and submit it electronically to UPMC Health Plan in **Optum OB Care** or **EpicCare (EPIC)**. For questions about submitting the form electronically, providers may call **Provider Services** at **1-844-860-9303** or the **UPMC Health Plan Maternity Program** at **1-866-778-6073.**

UPMC-owned ob-gyn providers will utilize **EPIC.** All other providers and UPMC-owned providers without EPIC will utilize the **Optum OB Care** web tool. For questions about the form or to obtain information about using the Optum OB Care web tool providers may also call the **UPMC Health Plan Maternity Program** at **1-866-778-6073.**

Depression Screening Tools

Providers are required to screen pregnant Participants for depression both prenatally and post-partum using one of the 2013 DHS validated depression screening tools.

Forms, screening tools, and instructions are also available online in the Medical Prior Authorization Resources section at:
upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.

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

Linguistic and Disability Competency

In addition to Title VI compliance and ADA accessibility requirements outlined in Chapter B (Provider Standards and Procedures) of the UPMC Health Plan provider manual, UPMC Community HealthChoices providers must also comply with the following minimum requirements as appropriate to their setting and services:

- Participants with physical disabilities (including those who use wheelchairs) must be able to independently access provider's office via accessible route from parking lot or public transportation (includes being able to open doors, traverse sidewalks and entrances, approach check-in desk, enter exam room, etc.).

- Participants with physical disabilities (including those who use wheelchairs) must be able to access and use a restroom within the building in which provider's office is located (preferably within provider's office or suite).

- Provider must allow for extended appointment times to accommodate disability and communication needs.

- Provider must provide foreign language, American Sign Language (ASL) and tactile interpreters upon request via onsite or video remote/over the phone interpreters.

- Provider must ask Participants at time of appointment scheduling if any disability or communication accommodations will be needed for the Participant's visit.

- Providers must allow service animals to accommodate Participants and visitors during appointments.

- Providers must provide Participants with written communication in an alternative format upon request (Braille, large print, foreign language, audio, etc.).

- Provider must respond to disability complaints in a timely manner and keep record of such complaints.

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

For additional information about interpreters, VRI or other disability-related accommodations, contact **UPMC's Disabilities Resource Center** at **412-605-1483** or **disabilitiesresource@upmc.edu**. For assistance, contact **Provider Services at 1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

Closer Look at Working with Interpreters

When working with interpreters, the provider should follow these tips for best communication with Participants:

- Have a direct conversation with the Participant, not the interpreter
- Do not ask the interpreter questions about the Participant; allow Participant to provide all needed information.
- Before speaking, get the attention of the Participant (slight wave or shoulder tap).
- Face the Participant; avoid obstructing your face.
- Speak in normal tone and pace; the interpreter will let you know if you are speaking too quickly.
- Don’t make small talk with the interpreter (while excluding the Participant).

Closer Look at Alternative Format Documentation

It is the provider’s responsibility to provide alternative format documents to Participants who cannot utilize standard written communication. This includes all forms of written communication and may include formats such as foreign language, audio, Braille, and large print.

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

Competency will be monitored and measured via on-site accessibility assessments, review of complaints and grievances, and ongoing follow-up by UPMC’s Provider Network Department. Questions regarding cultural, linguistic and disability competency can be asked by calling **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

Alzheimer's Disease and Other Dementias

Providing quality care to Participants with Alzheimer's disease or other dementias can be challenging. It is important to understand the symptoms of these diseases and the care a Participant requires throughout the course of their disease. The links below will help you to better assess, diagnose and treat a Participant with Alzheimer's disease or other dementias.

Title: Alzheimer's and Dementia Resources for Professionals
From: National Institutes of Health (NIH): National Institute on Aging (NIA)

Resources for Professionals Website:
nia.nih.gov/health/alzheimers-dementia-resources-for-professionals

Title: Healthcare Professionals - Resources and Information
From: The Alzheimer's Association

Healthcare Professionals Website**:**
alz.org/professionals/healthcare-professionals

Clinical Resources Website:
alz.org/professionals/healthcare-professionals/clinical-resources

Physician Pocket Card App**:**
alz.org/professionals/healthcare-professionals/clinical-resources/physician_pocketcard_app

Other Services

Other services available to UPMC Community HealthChoices Participants include:

Health Management Programs

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

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

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

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

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

UPMC Community HealthChoices offers the following health education classes:

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

Additional information on health management programs can be found online at **upmchealthplan.com/providers/medical/resources/other/patient-health.aspx** in the Patient Health section under Resources & Information.

UPMC *My*Health 24/7 Nurse Line

The UPMC *My*Health 24/7 Nurse Line is an advice line available for Participants seeking general health advice or information regarding a specific medical issue or medical questions concerning both adults and children.

Experienced registered nurses are available **24 hours a day, 7 days a week, 365 days a year** to provide Participants with prompt and efficient services.

The Participant may call **1-866-918-1591 (TTY: 711)** any time or log onto ***My*Health OnLine.**

- See **upmchealthplan.com/members/learn/benefis-and-services/nurse-line.aspx** for additional information.

UPMC AnywhereCare

AnywhereCare Virtual Urgent Care—UPMC Health Plan's telemedicine tool—offers Participants access to high-quality care from the comfort of their own home day or night. It works well for issues such as rashes, sore throats, colds, and other nonemergency issues. Participants can have a Virtual Urgent Care visit with a provider right from their smartphone, tablet, or computer. The Participant downloads UPMC AnywhereCare mobile app from the iTunes App Store or Google Play by searching for "UPMC AnywhereCare." or they can register at **upmcanywherecare.com** from their computer.

Providers interested in participating as an AnywhereCare provider should contact **Provider Services** at **1-844-860-9303** or their physician account executive.

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

UPMC Community HealthChoices complies with continuity of care requirements for continuation of providers, services, and any ongoing course of treatment outlined in **Medical Assistance Bulletin #99-03-13**, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.

➢ See **phca.org/wp-content/uploads/2018/07/MAB-99-03-13.pdf.**

Physical Health Services
If a Participant, upon enrolling in UPMC Community HealthChoices is receiving physical health services authorized by another Physical Health Managed Care Organization (PH-MCO), Community HealthChoices Managed Care Organization (CHC-MCO) or by the Medical Assistance fee-for-service (FFS) program, those services will continue for **up to 60 days** after enrollment with UPMC Community HealthChoices. Utilization Management will conduct a concurrent clinical review of all pertinent information to determine if the services are medically necessary beyond the initial authorization period. The length of time that the service will continue will vary depending on if the Participant is pregnant. However, the provider still must notify UPMC Community HealthChoices with information regarding those services. The provider must contact **Utilization Management** through **Provider OnLine** at **upmchealthplan.com/providers**. Out-of-network providers must contact **Utilization Management** at **1-800-425-7800.**

Home and Community Based Services
If a Participant, upon enrolling in UPMC Community HealthChoices is receiving Home and Community Based services authorized by another CHC-MCO, those services will continue for **60 days or until a comprehensive needs assessment has been completed** and a person-centered service plan (PCSP) has been developed and implemented, whichever date is earlier.

For Participants who are pregnant:

If a pregnant Participant is already receiving care from an out-of-network ob-gyn provider at the time of enrollment with UPMC Community HealthChoices, the Participant may choose to continue to receive an ongoing clinically appropriate course of treatment from that specialist throughout the pregnancy and postpartum care related to the delivery.

Before authorization from the previous PH-MCO, CHC-MCO or fee-for-service program expires, the provider needs to review prior authorization and referral requirements for the service(s) and make the necessary prior authorization request.

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

Questions regarding services prior authorized by another MCO or Fee-for-Service can be directed to **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

Services Not Covered

The following services are not covered under the UPMC Community HealthChoices program unless requested as a Program Exception and prior authorization is obtained from the Utilization Management Department. Providers must contact **Utilization Management by submitting a request through Provider OnLine** at **upmchealthplan.com/providers** to determine if a service is eligible to be considered for a prior authorization.

- Acupuncture
- Experimental or investigative treatments
- Home and vehicle modifications
    - **NOTE**: UPMC Community HealthChoices Participants with LTSS may be eligible for this service.
    - See ***Covered Services*** for more information or call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.
- Infertility services
- Medical services or surgical procedures and diagnostic tests performed on an inpatient basis that could have been performed in the provider's office, the clinic, the emergency department, or a short procedure unit without endangering the life or health of the Participant
- Non-medically necessary treatments or surgery (e.g., cosmetic surgery)
- Out-of-Country care, (Services provided outside of the United States)
    - See ***Out-of-Area or Out-of-Network Care***, UPMC Community HealthChoices (Medical Assistance), Chapter N.
- Out-of-network care, except for emergency services and family planning
- Self-directed care, except as noted in the Coordinated Care section.
    - See ***Coordinated Care***, UPMC Community HealthChoices (Medical Assistance), Chapter N.

Program Exception Process

The program exception process occurs when a provider requests Utilization Management review of a service that is not a covered benefit to determine if an exception should be made based on medical necessity. The process also applies to benefit limit exception requests for additional treatment for a Participant who has exhausted the benefit limit (i.e., duration or quantity) of a particular service.

The Utilization Management Department will consider requests by providers for program exceptions and benefit limit exceptions for UPMC Community HealthChoices Participants.

Providers must submit program exception or benefit limit exception requests to **Utilization Management** by accessing **Provider OnLine** at **upmchealthplan.com/providers** and entering the authorization request or by sending a letter to:

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

A provider must submit the following information to request an exception:

- Participant's name
- Participant's address and telephone number
- Participant's UPMC Community HealthChoices Participant ID
- A description of the service for which the provider or the Participant is requesting an exception
- The reason the exception is necessary
- Supporting clinical documentation demonstrating the medical necessity of the service/item
- The provider's name and telephone number

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

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

If a service that is not on the fee schedule or normally requires a prior authorization is delivered in an emergency, UPMC Community HealthChoices will respond within **30 days** upon receipt of the request.

An exception request made after the service has been delivered must be submitted through the provider appeal process no later than **60 days** from the date UPMC Community HealthChoices rejects the claim. Exception requests made after **60 days** from the claim rejection date will be denied.

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

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

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

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

To request a program exception for a UPMC Community HealthChoices Participant, the provider should submit a request to Utilization Management and offer supporting information demonstrating the medical necessity of the exception.

Participants may request their provider initiate a program exception on their behalf. Participants can contact the UPMC Community HealthChoices Health Care Concierge team if they need assistance or have any questions on how to request a program exception.

Urgent pre-service requests are reviewed for medical necessity and a determination will be made within **24 hours**. Providers will receive oral notification of the decision within **24 hours** of receipt of the request in addition to a written notification. The written notification is sent to the provider within **24 hours** and a copy is sent to the Participant.

Non-urgent pre-service requests are reviewed for medical necessity and a determination will be made within **two business days**. Providers will receive oral notification of the decision within **two business days** of receipt of the request. In addition, the provider will receive written notification within **two business days** of the oral notification.

If the Participant is currently receiving a service that is terminated or reduced based on the medical necessity review, the effective date of the termination or reduction of that service will be **10 days** from the date of the denial notice. If the Participant requests an appeal within **10 days** of the date of the denial notice, the services will continue at the previously approved level until a decision is rendered in the appeal.

Closer Look at Benefit Limit Exceptions

Benefit Limit Exception:

An exception to service limits may be granted if the UPMC Community HealthChoices Participant:

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

Dental Benefit Limit Exception:

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

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

Service Coordination

Role of Service Coordinators

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

The Service Coordinator's role includes the following activities:

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

For more information or to speak with a Service Coordinator, contact the **Service Coordination Department** at:

Service Coordination Department	
Southwest Pennsylvania	**1-844-860-9302**
Southeast Pennsylvania	**1-833-672-8078**
Remainder of Pennsylvania	**1-833-280-8508**

Role of the Provider for Participants who Receive LTSS

Providers have an integral role in the goal of seamless and continuous, Participant-centric care. UPMC Health Plan wants providers to have access to necessary supports and resources to enable them to appropriately and safely complete assigned tasks and responsibilities for participants by providing the various topics and contact information in this handbook. To help achieve that goal, both medical and non-medical providers should:

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

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

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

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

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

➢ See ***Critical Incident Reporting***, UPMC Community HealthChoices (Medical Assistance), Chapter N.

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

Person-Centered Planning Teams

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

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

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

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

Comprehensive Needs Assessment and Reassessment

Once determined Nursing Facility Clinically Eligible (NFCE) by the independent enrollment broker, a Comprehensive Needs Assessment, also referred to as an interRAI-Home Care (HC), is completed for all Participants who prefer to receive services in the community. A Comprehensive Needs Assessment may also be completed for a Participant who is not NFCE, but the Participant requests a needs assessment, self-identifies as needing LTSS, or is identified as having unmet needs, service gaps, or a need for service coordination.

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

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

The assessment comprises key elements to identify and evaluate the Participant's needs, including:

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

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

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

An assessment is conducted no later than **five business days** from the Participant's start date for Participants who are eligible for LTSS but not receiving LTSS on their enrollment date and for dual eligible Participants identified by the IEB as having a need for immediate services.

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

Person-Centered Service Plans (PCSP)

The PCSP is a written, holistic approach to addressing the Participant's physical, cognitive, behavioral, social, and environmental needs. It is created no more than **30 days** from the date of the Comprehensive Needs Assessment.

The PCSP is created with the Participant or designated representative in a culturally and linguistically appropriate manner that fully incorporates the Participant's preferences, strengths, goals, and expectations for their services.

Service Coordinators assist the Participant in making informed choices about their services and getting access to covered services identified in the PCSP. The Participant has a right to request updates to the PCSP as needed.

The PCSP comprises two key components:

- The Care Plan
- The Service Plan

Care Plan:

Service Coordinators develop a holistic Care Plan that identifies and addresses how the Participant's physical, cognitive, behavioral, social, environmental, and functional needs are addressed and coordinated.

The Care Plan includes:

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

Service Plan:

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

The Service Plan includes:

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

Provider Critical Incident Reporting Requirements

Reporting Requirements

UPMC Community HealthChoices requires **all network providers** to **report all Critical Incidents** involving UPMC Community HealthChoices Participants to the Participant's Service Coordinator within **24 hours** of discovery, and after ensuring the health and safety of the Participant.

For all incidents that meet the state's criteria for critical incidents, the direct service providers must report the incidents in the state's **Enterprise Incident Management (EIM) system** within **48 hours**.

All investigations and follow up activities must be completed and documented in EIM within **30 days**. Other providers may submit a typed critical incident form that is available on the UPMC Health Plan website **upmchealthplan.com/providers/hcbs/resources** to **chc_critical@upmc.edu** within **24 hours from the date of discovery** and UPMC Community HealthChoices will submit the incident in the state's EIM system. Any type of provider may use the online form as an alternative reporting method if the EIM system is not working.

Requesting EIM access

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

Training

Providers must participate in an EIM training to learn about the changes made to the system for Community HealthChoices Participants. Providers will have access to training webinars and education materials through the UPMC Health Plan website. Providers must participate in trainings offered by UPMC Community HealthChoices to ensure accurate and timely reporting all critical incidents. Trainings may be offered at webinars, online or in person at regional meetings. To request training materials or notices, email **chc_critical@upmc.edu.**

Critical Incidents Categories

The following categories of incidents are considered reportable for UPMC Community HealthChoices participants enrolled in HCBS:

- **Death** (if suspicious in nature or unexpected only)
- **Serious injury** that results in emergency room visits, hospitalizations, or death
- **Unplanned hospitalization**
- **Provider or staff misconduct**, including deliberate, willful, unlawful, or dishonest activities
- **Emergency room visits**
- **Abuse**, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a Participant. Types of abuse include, but not limited to:
    - Physical abuse, defined as a physical act by an individual that may cause physical injury to a Participant.
    - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade, or demean a Participant.
    - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a Participant.
    - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a Participant.
- **Neglect**, which includes failure to provide a Participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Neglect includes:
    - Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.
    - Abandonment, which is the desertion by anyone who assumed caregiving responsibilities for a Community HealthChoices Participant.
- **Exploitation**, which is an act of depriving, defrauding, or otherwise obtaining the personal property from a Participant in an unjust or cruel manner against one's will or without one's consent or knowledge for the benefit of self or others.
- **Restraint**, which includes any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations, or activities, or restricts Participant rights.

- **Service interruption**, which includes any event that results in the Participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the Participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization.
- **Medication errors** that result in hospitalization, an emergency room visit, or other medical intervention.
- **Any Preventable Serious Adverse Events (PSAEs)** discovered in a nursing facility must be reported in compliance with the **Office of Long-Term Living bulletin #03-14-08 issued 09/13/2014 and effective 10-01-2014**. The facility must also notify UPMC Community HealthChoices on the claim and email it to **chc_critical@upmc.edu.**

Immediate First Steps for Suspected Abuse, Neglect, Exploitation Incidents

Any provider, Service Coordinator, subcontractor, or UPMC employee who observes or has reasonable cause to **suspect that abuse, neglect, exploitation, abandonment, or suspicious or unexpected death** has occurred with a Community HealthChoices Participant are mandatory reporters and must:

1. **Take immediate action to ensure the Participant's health and safety.** If the Participant's health or well-being is in imminent danger, notify emergency first responders **(911)**.

2. **Make a verbal report to the state Adult Protective Services (APS) Hotline** at **1-800-490-8505.** Any questions requiring immediate attention outside of regular business hours should be directed to the APS' contractor - **Liberty Healthcare's on-call staff** at **1-888-243-6561**.

   - **NOTE**: Liberty Healthcare should **only be contacted for emergency situations** requiring immediate attention.

3. **Within 24 hours, call the UPMC Community HealthChoices Service Coordination Department.** If there is no answer, then contact the **UPMC Community HealthChoices Health Care Concierge team**.

Service Coordination Department	
Southwest Pennsylvania	**1-844-860-9302**
Southeast Pennsylvania	**1-833-672-8078**
Remainder of Pennsylvania	**1-833-280-8508**

   a. **Make a verbal report to the UPMC Community HealthChoices Health Care Concierge team** at **1-844-833-0523** within **24 hours**.
      i. At a minimum, the verbal report must include Participant's full name, date of birth, date and time of incident, a brief description of the incident, Participant's current condition, and actions taken to mitigate risk to the Participant; and

      ii. The reporter's name, agency, and contact information.

4. **Submit a critical incident report** to the state's EIM system or use the UPMC incident report form available on the UPMC Community HealthChoices Provider Resources website at **upmchealthplan.com/providers/hcbs/resources/** and can be submitted through a secure email to **chc_Critical@upmc.edu** or by sending a **fax** to **412-454-5357.**

   - **NOTE**: If a provider encounters a situation when serving a participant that requires access to emergency services for their safety and protection, the provider should contact local law enforcement and protective services as needed, then notify their regional UPMC Service Coordination Department at the phone numbers provided above. UPMC Health Plan will route the information to the designated unit to respond for additional provider support.

Possible Actions Needed After an Incident

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

- Contact **911** if the incident can cause or did cause immediate/severe harm to the Participant.
- Remove worker from the Participant's services (if incident includes allegation of improper behavior by that worker).
- Remove accused worker from servicing any UPMC Community HealthChoices Participant until the investigation is complete. This may take up to **30 calendar days.**
- Interview involved employee(s) as soon as possible following the incident.
- Have the employee(s) submit a written account of events.
- Comply with any investigations from UPMC Health Plan or external agencies, including but not limited to Protective Services, law enforcement, Bureau of Program Integrity, or the Attorney General's office.
- Electronically submit written accounts, statements and case details through **secure email** to **chc_critical@upmc.edu** or by **fax** to **412-454-5357.**
- Obtain fax numbers, phone numbers, or email addresses for UPMC Community HealthChoices staff by calling the **UPMC Community HealthChoices Health Care Concierge team** at **1-844-833-0523.**

Follow-Up Responsibilities

Providers must cooperate fully in the investigation of reported critical incidents, including submitting all requested documentation within specified timelines. If the incident involves an employee of a HCBS provider, the provider must also submit within **20 calendar days of the incident** a written report of the incident, including actions taken. Based upon the severity of the incident, any identified trend or failure on the part of the provider to cooperate with any part of the investigation, the provider may be required by UPMC Health Plan to submit a written plan of correction to address and correct any problem or deficiency surrounding the critical incident.

Additional Provider Requirements

All network providers of UPMC Community HealthChoices acknowledge and agree to comply with the following requirements:

- As required by the Department of Human Services, UPMC Community HealthChoices may offset any past due amount that a provider owes to the Department against any payments due to the provider under the Provider Agreement; provided that the Department or UPMC Community HealthChoices first provides written notice of its intention to do so.

- Providers within UPMC Community HealthChoices' provider network are prohibited from soliciting Participants to receive services from the provider, including:
    - Referring an individual for Community HealthChoices evaluation with the expectation that, should Community HealthChoices enrollment occur, the provider will be selected by the Participant as the service provider;

    - Communicating with existing Community HealthChoices Participants via telephone, face-to-face or written communication for the purpose of petitioning the Participant to change providers;

    - Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential Community HealthChoices Participants.

Medical Assistance Provider Compliance Hotline

If a provider has knowledge of suspected Medical Assistance provider noncompliance, recipient or provider fraud, waste, or abuse, or of substandard quality of care for services paid for under the Pennsylvania Medical Assistance Program, contact the **MA Provider Compliance Hotline** at **1-866-379-8477.**

Recipient fraud is defined as someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

Provider fraud is defined as billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

Reported problems will be referred to the Office of Administration's Bureau of Program Integrity for investigation, analysis, and determination of the appropriate course of action.

The hotline number operates Monday through Friday from 8:30 a.m. to 4 p.m. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

➢ *See **Provider Role in: Reporting Fraud, Waste and Abuse to UPMC Health Plan***, Provider Standards and Procedures, Chapter B.

Participant Complaint, Grievance, and Fair Hearing Procedures

UPMC Community HealthChoices Participants have a Complaint, Grievance, and Fair hearing process available to them if they are unhappy about services provided by UPMC Community HealthChoices or their provider.

In order for the provider to represent the Participant in the conduct of a Grievance, the provider must obtain the written consent of the Participant and submit the written consent with the Grievance. A provider may obtain the Participant's written permission at the time of treatment. A provider cannot require a Participant to sign a document authorizing the provider to file a Grievance as a condition of treatment.

The written consent must include all of the following:

- The name and address of the Participant, the Participant's date of birth, and identification number.
- If the Participant is legally incompetent, the name, address, and relationship to the Participant of the person who signed the consent.
- The name, address, and UPMC Community HealthChoices identification number of the Provider to whom the Participant is providing consent.
- The name and address of UPMC Community HealthChoices.
- An explanation of the specific service or item which was provided or denied to the Participant to which the consent will apply.
- The following statement:
    - "*The Participant or the Participant's representative may not submit a Grievance concerning the service or item listed in this consent form unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process."*
- The following statement:
    - "*The consent of the Participant or the Participant's representative shall be automatically rescinded if the provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process."*

- The following statement:
  - *"The Participant or the Participant's representative, if the Participant is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Participant or the Participant's representative understands the information in the Participant's consent form."*

- The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.

A detailed summary of the Participant Complaint and Grievance Procedures, can be found in the UPMC Community HealthChoices Participant Handbook at **upmchealthplan.com/chc/members/documents-and-resources.**

For an expedited complaint or grievance, the provider must indicate in writing that a Participant's life or health is at risk. UPMC Community HealthChoices will send a letter within **48 hours** of receiving the provider certification or **72 hours** of receiving the Participant's request for an expedited review, whichever is sooner, informing the Participant of its decision.

> **NOTE**: The UPMC Community HealthChoices Participant Complaint, Grievance and Fair hearing process is separate and distinct from the Provider Dispute process outlined in **Chapter B,** Provider Standards and Procedures.

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

Provider Monitoring

The UPMC Community HealthChoices Provider Monitoring Team is responsible for ensuring that UPMC Health Plan-enrolled LTSS providers, actively serving UPMC Community HealthChoices Participants, are compliant with all standards and requirements set forth in **55 Pa. Code Chapter 52, Community HealthChoices 1915(c) Waiver**, the Community HealthChoices Agreement between UPMC Health Plan and DHS, the UPMC Health Plan Provider Agreement, and the UPMC Health Plan Provider Manual.

The Provider Monitoring Team will conduct on-site monitoring of LTSS providers **at least once per two-year period.** More frequent monitoring may be necessary based on complaints, critical incidents, or other issues identified by UPMC Health Plan.

During these on-site monitoring meetings, the Provider Monitoring team's review will include, but not be limited to, verification of required policies and procedures, and review of employee files (including background checks and licensure, when appropriate).

LTSS Providers must have established qualifications (e.g., job descriptions) for each position, conduct background checks on all employees who provide direct care to Participants, and utilize an additional tool (e.g., an interview or, reference checks) for each paid employee hired. Providers must share documentary evidence of these requirements for each employee with UPMC Health Plan upon request.

Electronic Visit Verification

UPMC Health Plan requires the use of Electronic Visit Verification (EVV) for certain Home and Community Based Services. As of January 1, 2020, EVV must be used for all Personal Assistance Services (PAS) or Respite Services provided to UPMC Community HealthChoices participants by HCBS Providers.

In order to fulfill the EVV requirement, the following data must be captured and provided to UPMC Health Plan:

- Type of service performed
- Participant receiving the service
- Individual providing the service
- Date of the service
- Location of service delivery
- Time the service begins and ends

All data must be remitted using procedures communicated to HCBS Providers by UPMC Health Plan. EVV data must be unedited to be considered valid. If there are any changes to the original timestamp, HCBS Providers must also provide the following additional information:

- The name of the individual who authorized the change
- The reason the change was made

HCBS Providers will be monitored for compliance with EVV requirements, in accordance with UPMC Health Plan policies and procedures.

UPMC Health Plan's policies and procedures regarding EVV will be updated from time to time. Failure to comply with UPMC Health Plan policies and procedures regarding EVV may result in a Provider Corrective Action Plan and/or non-payment for services.

> ➢ See ***UPMC Health Plan's secure Provider OnLine website*** at **upmchealthplan.com/providers** for the most current requirements, compliance and guidelines for EVV.

UPMC Community HealthChoices will follow DHS requirements for EVV implementation dates for Home and Community Based Services other than PAS and Respite Services.

Other Resources and Forms

Telehealth and Clinical Practice Guidelines

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

Medical Prior Authorization

- Prior Authorization Information Materials
- Patient Health Guidelines
- Physician Forms

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

Pharmacy Prior Authorization

- Prior authorization forms

- **upmchealthplan.com/providers/medical/resources/forms/pharmacy-pa.aspx**

Copayment Schedule

UPMC Community HealthChoices Participants do not have Medical Assistance copayments for services and medical equipment received. Participants are subject to Medical Assistance pharmacy copayments. If the Participant is dual eligible, the Participant is still responsible for all Medicare copayments for pharmacy services.

Table N5: Copayments Schedule – Adult Medical Assistance Participants

Services	Copay
Ambulance (per trip)	$0
Dental Care	$0
Diagnostic Services (Not performed in a doctor's office)	
Medical diagnostic testing (per service)	$0
Nuclear medicine (per service)	$0
Radiation therapy (per service)	$0
Radiology diagnostic testing (per service)	$0
Inpatient Hospital (Acute or Rehab)	
Per day	$0
Maximum with limits	$0
Medical Centers	
Ambulatory Surgical Center	$0
Convenience care or Urgent care centers	$0
Emergency Department (nonemergent visits)	$0
Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)	$0
Short procedure unit	$0
Medical Equipment	
Purchase or rental	$0
Medical Visits	
Certified nurse practitioner	$0
Chiropractor	$0
Doctor (PCP- Ob/gyn)	$0
Optometrist	$0
Podiatrist	$0
Therapy; (Occupational, Physical, Speech)	$0
Outpatient Hospital (Includes Hospital Based Clinics)	
Per visit	$0
Prescriptions	
Brand	**$3**
Generic	$0