UPMC Health Plan Behavioral Health Services

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At a Glance

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

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

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

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

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

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

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

➢ **See:** ***UPMC Health Plan Behavioral Health Services (BHS) Key Contacts – Table A1,*** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

➢ **See:** ***Glossary & Abbreviations,*** UPMC Health Plan Provider Manual, Chapter K.

Any questions about material in the UPMC Health Plan Behavioral Health Services (UPMC Health Plan BHS) section of the UPMC Health Plan Provider Manual, call **UPMC Health Plan BHS** at **1-866-441-4185.** Representatives are available **24 hours a day, 7 days a week, 365 days a year.**

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Providing Behavioral Health Services to UPMC Health Plan Members

Behavioral Health Service Authorization Procedures

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

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

Out-of-network providers **must** call **1-866-441-4185** to request prior authorization. Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year.**

➢ **See:** ***Provider OnLine,*** UPMC Health Plan Provider Manual, Chapter A**,** Key Contacts for complete Provider OnLine instructions for in- and out-of-network providers.

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

➢ **See: Tables:**

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

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Table L1: Inpatient Mental Health

Service	Authorization Requirements
Inpatient Mental Health	Inpatient Mental Health services **require prior authorization**. ➢ **Note:** Effective **July 21, 2021,** UPMC *for Kids* (CHIP) **requires prior authorization** for medically necessary in-network inpatient mental health services. • **Medical necessity criteria**, as set forth in the InterQual Behavioral Health and Substance Use Disorders Criteria, are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Adult and Geriatric Psychiatry-Inpatient*** or Behavioral Health: ***Child and Adolescent Psychiatry-Inpatient*** for in-depth criteria. • **Continued-stay reviews** can be completed on the **last covered day** authorized or **one business day** after the **last covered day** authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.

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Table L2: Inpatient Detoxification, Drug and Alcohol (includes nonhospital facilities)

Service	Authorization Requirements
Inpatient Detoxification, Drug and Alcohol (includes nonhospital facilities)	Inpatient Detoxification, Drug and Alcohol services **require prior authorization.** These services include nonhospital facility-based services. ➢ **Note:** Effective **July 21, 2021,** UPMC *for Kids* (CHIP) **requires prior authorization** for medically necessary in-network inpatient detoxification. • **Medical necessity criteria**, as set forth in the InterQual Behavioral Health and Substance Use Disorders Criteria, are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Substance Use Disorders-Inpatient Detoxification*** (for hospital-based detoxification units and non-hospital-based detoxification units) sections. • **Continued-stay reviews** can be completed on the **last covered day** authorized or **one business day** after the **last covered day** authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.

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Table L3: Inpatient Rehabilitation, Drug and Alcohol (includes nonhospital facilities)

Service	Authorization Requirements
Inpatient Rehabilitation, Drug and Alcohol (includes nonhospital facilities)	Inpatient Rehabilitation, Drug and Alcohol services **require prior authorization.** These services include nonhospital facility-based services. ➢ **Note:** Effective **July 21, 2021,** UPMC *for Kids* (CHIP) **requires prior authorization** for medically necessary in-network inpatient rehabilitation. • **Medical necessity criteria,** as set forth in the InterQual Behavioral Health and Substance Use Disorders Criteria, are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Substance Use Disorders-Inpatient Rehabilitation*** (for hospital-based rehabilitation units) or Behavioral Health: ***Substance Use Disorders-Residential Treatment Center*** (for non-hospital-based rehabilitation units) sections for in-depth criteria. • **Continued-stay reviews** can be completed on the **last covered day** authorized or **one business day** after the **last covered day** authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.

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Table L4: Mental Health Residential Treatment

Service	Authorization Requirements
Mental Health Residential Treatment	Mental Health Residential Treatment **requires prior authorization.** ➢ **Note:** Effective **July 21, 2021,** UPMC *for Kids* (CHIP) **requires prior authorization** for medically necessary in-network residential mental health services. • **Medical necessity criteria**, as set forth in the InterQual Behavioral Health and Substance Use Disorders Criteria are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Adult and Geriatric Psychiatry-Residential Treatment Center*** or Behavioral Health: ***Child and Adolescent Psychiatry-Residential Treatment Center*** sections for in-depth criteria. • **Continued-stay reviews** can be completed on the **last covered day** authorized or **one business day** after the **last covered day** authorized, and it is the facility's responsibility to submit the request for additional authorization in a timely manner.

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Table L5: Mental Health Partial Hospitalization Program

Service	Authorization Requirements
Mental Health Partial Hospitalization Program	Any medically necessary in-network claim for a Mental Health Partial Hospitalization Program will be considered for payment **without an authorization.** For Members **with out-of-network benefits,** any medically necessary out-of-network claim for a Mental Health Partial Hospitalization Program will be considered for payment at the out-of-network benefit level **without an authorization.** For Members **without out-of-network benefits,** a claim for out-of-network Mental Health Partial Hospitalization Program **requires prior authorization.** Providers **must** call **UPMC Health Plan BHS** at **1-866-441-4185** to obtain authorization. Requests for prior authorization **must** meet the criteria set forth in UPMC Health Plan Policy Number CRM.014 (Authorization of Out of Network Care and Benefit Elevation), which is available at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx**. Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year.** • The InterQual Behavioral Health and Substance Use Disorders Criteria are used for decisions about prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Adult and Geriatric Psychiatry-Partial Hospital Program*** or Behavioral Health: ***Child and Adolescent Psychiatry-Partial Hospital Program*** sections for in-depth criteria.

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Table L6: Drug and Alcohol Partial Hospitalization Program

Service	Authorization Requirements
Drug and Alcohol Partial Hospitalization Program	Any medically necessary in-network claim for a Drug and Alcohol Partial Hospitalization Program will be considered for payment **without an authorization.** For Members **with out-of-network benefits,** any medically necessary out-of-network claim for a Drug and Alcohol Partial Hospitalization Program will be considered for payment at the out-of-network benefit level **without an authorization.** For Members **without out-of-network benefits**, an out-of-network claim for Drug and Alcohol Partial Hospitalization Program **requires prior authorization.** Providers **must** call **UPMC Health Plan BHS** at **1-866-441-4185** to obtain authorization. Requests for prior authorization **must** meet the criteria set forth in UPMC Health Plan Policy Number CRM.014 (Authorization of Out of Network Care and Benefit Elevation), which is available at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.** Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year.** • The InterQual Behavioral Health and Substance Use Disorders Criteria are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Substance Use Disorders-Partial Hospital Program*** section.

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Table L7: Mental Health Intensive Outpatient Program

Service	Authorization Requirements
Mental Health Intensive Outpatient Program	Any medically necessary in-network claim for Mental Health Intensive Outpatient Program will be considered for payment **without an authorization.** For Members **with out-of-network benefits,** any medically necessary out-of-network claim for Mental Health Intensive Outpatient Program will be considered for payment at the out-of-network benefit level **without an authorization.** For Members **without out-of-network benefits,** an out-of-network claim for Mental Health Intensive Outpatient Program **requires prior authorization.** Providers **must** call **UPMC Health Plan BHS** at **1-866-441-4185** to obtain authorization. Requests for prior authorization **must** meet the criteria set forth in UPMC Health Plan Policy Number CRM.014 (Authorization of Out of Network Care and Benefit Elevation), which is available at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.** Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year.** • The InterQual Behavioral Health and Substance Use Disorders Criteria are used for decisions about prior authorizations and continued stays. ➢ **See:** Behavioral Health: ***Adult and Geriatric Psychiatry-Intensive Outpatient Program*** or Behavioral Health: ***Child and Adolescent Psychiatry-Intensive Outpatient Program*** section.

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Table L8: Drug and Alcohol Intensive Outpatient Program

Service	Authorization Requirements
Drug and Alcohol Intensive Outpatient Program	Any medically necessary in-network claim for Drug and Alcohol Intensive Outpatient Program will be considered for payment **without an authorization.** For Members **with out-of-network benefits**, any medically necessary out-of-network claim for Drug and Alcohol Intensive Outpatient program will be considered for payment at the out-of-network benefit level **without an authorization.** For Members **without out-of-network benefits,** an out-of-network claim for Drug and Alcohol Intensive Outpatient program **requires prior authorization.** Providers **must** call **UPMC Health Plan BHS** at **1-866-441-4185** to obtain authorization. Requests for prior authorization **must** meet the criteria set forth in UPMC Health Plan Policy Number CRM.014 (Authorization of Out of Network Care and Benefit Elevation), which is available at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.** Care managers are available to providers **24 hours a day, 7 days a week, 365 days a year**. • The InterQual Behavioral Health and Substance Use Disorders Criteria are used for decisions regarding prior authorization and continued stays. ➢ **See:** Behavioral Health: ***Substance Use Disorders-Intensive Outpatient Program*** section.

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

Service	Authorization Requirements
Outpatient Behavioral Health Services, Mental Health and Drug and Alcohol	• Any medically necessary in-network claim submitted for psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or drug and alcohol use disorders will be considered for payment **without an authorization.** • For Members **with out-of-network benefits**, medically necessary out-of-network psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or substance use disorders **will pay at the Member's out-of-network benefit level.** A provider can verify eligibility for out-of-network benefits based on the individual's plan by calling **UPMC Health Plan BHS** at **1-866-441-4185.** • For Members **without out-of-network benefits,** out-of-network psychological testing, neuropsychological testing, or outpatient treatment for mental health disorders or substance use disorders, **will require a prior authorization.** To submit this request, complete the medical necessity form for out-of-network requests, which is located at **p.widencdn.net/apb6mg/providers_mnf-oon_web.** Fax the completed form to **412-454-2057.** Requests for prior authorization **must** meet the criteria set forth in UPMC Health Plan Policy Number CRM.014 (Authorization of Out of Network Care and Benefit Elevation), which is available at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.**

Closer Look at Behavioral Health Service Authorizations

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

- Members are to be held financially harmless if the provider fails to follow the authorization procedures. Members **cannot** be billed for services if the provider fails to obtain the proper authorization.

- Providers need to routinely check with the Member concerning any change in their insurance coverage on a routine basis. Members may change insurance plans and neglect to inform the provider.

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- Member benefits for each level of care vary according to the Member's employer and/or the particular insurance plan in which the Member is enrolled. Discuss benefit limitations with the Member or call **UPMC Health Plan BHS** at **1-866-441-4185** to verify benefits. Representatives are available **24 hours a day, 7 days a week, 365 days a year.**

- It is important that providers notify UPMC Health Plan about any changes to contact information or services offered so that Members can be given accurate referral assistance.

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

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

Key Points

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

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

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Verifying Member Eligibility for UPMC Health Plan BHS
Claims for behavioral health services are paid when a Member is eligible to receive behavioral health services on the date the Member receives services from the provider.

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

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

Medical Necessity Criteria

At the time of the Member's initial visit, an evaluation of the Member will occur to determine what behavioral health services may meet the Member's needs. However, before providing services, the provider **must** make sure the services meet medical necessity criteria for that level of care. UPMC Health Plan BHS uses medical necessity criteria in determining whether to issue a prior authorization for certain types of behavioral health service outlined below. If the Member's clinical condition necessitates a level of care that is covered in the Member's benefit plan, but that level of care is not available, the next highest covered benefit level of care will be authorized.

To obtain a copy of the Interqual Behavioral Health and Substance Use Disorders Medical Necessity Criteria, currently being utilized by UPMC Health Plan BHS for adults, adolescents, and children contact either:

- **UPMC Health Plan BHS** at **1-866-441-4185**.
  - **Note:** Care managers are available **24 hours** a day, 7 days a week, 365 days a year.

- **Change Health Care**
  100 Airpark Center Drive East
  Nashville, TN 37217
  Phone: 1-866-371-9066

Obtaining Prior Authorizations and Other Utilization Review Activity

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

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

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

- **See:** ***Behavioral Health Services Requirements, Tables L1- L9.***

- **See:** ***Provider OnLine,*** in the Behavioral Health Services Section of the UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts, for complete Provider OnLine instructions.

Alert – Receiving Prior Authorization

Receiving prior authorization is **not** a guarantee that the claim will be paid, as other criteria **must** be met. Payment is also contingent upon other requirements including, but **not** limited to, Member eligibility, concurrent review requirements, and focused or retrospective care management reviews. For certain services requiring prior authorization, additional information **must** be submitted to UPMC Health Plan BHS care managers before authorization is given. The specific process and documentation requirements will be explained during the prior authorization call with the UPMC Health Plan care manager.

Other Utilization Review Activity

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

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

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

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Alert – Care Management

Care management staff are **not** compensated financially, nor is their job performance rated, based upon the number of denials or limits on benefits authorized. UPMC Health Plan's utilization management decision-making is based only on appropriateness of care and service and existence of coverage. UPMC Health Plan **does not** specifically reward practitioners or other individuals for issuing denials of coverage or service and **does not** offer financial incentives for utilization management decision-makers.

Care Managers May Not Deny Care

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

Reviews by Peer Advisors

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

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

Other Clinical Reviews

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

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

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Provider Availability Standards

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

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

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

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

Behavioral Health Emergencies

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

- A **life-threatening** behavioral health emergency occurs when, as a result of a mental health or substance use disorder, there is reason to believe the Member is (or may become) homicidal or suicidal or the Member or Member's victim may suffer a disabling or permanent physical injury as a result of the Member's behavior or condition. The assessment that a life-threatening emergency exists is based upon statements or behavior, Member self-report, information obtained objectively, or clinical judgment.

  - **Note: Care is required <u>immediately</u> for life-threatening emergencies.**

- A **non-life-threatening** behavioral health emergency occurs, when as a result of a mental health or substance use disorder, the Member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made **within one hour.**

  - **Note: Care is required <u>within one hour</u> for non-life-threatening emergencies.**

Alert – Emergency Services

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

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

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

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

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

Urgent Behavioral Health Conditions

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

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

Alert – Access to Urgent Care

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

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Routine Outpatient Services

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

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

Alert – Access to Routine Services

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

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

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

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

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

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

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

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

Members for whom coordination of care is especially important include:

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

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

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

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Other Behavioral Health Network Provider Referrals

Referrals to other behavioral health network providers are appropriate when it is determined that a UPMC Health Plan Member requires behavioral health services that are not **within** the scope of the provider's practice. In these instances, call **UPMC Health Plan BHS** at **1-866-441-4185** and ask an intake coordinator for help in identifying network providers who can provide those services. Representatives are available **24 hours a day, 7 days a week, 365 days a year.**

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

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

Transition of Care to a Network Behavioral Health Provider

Transition of care to another network behavioral health provider may be necessary when a behavioral health provider is no longer participating in the network(s) affiliated with UPMC Health Plan.

When a behavioral health provider contract is voluntarily terminated, a transition period of **up to 90 days may** be allowed for Members under the terminated provider's care if the Member was in an ongoing course of treatment at the time of the termination.

Alert–A request for an extension up to **90 days does not apply** to UPMC *for Kids*. UPMC *for Kids* Members have a transition period **up to 60 days.**

- **Note:** The transition period **may** be extended by UPMC Health Plan if an extension is to be clinically appropriate. UPMC Health Plan will consult with the Member and the health care provider in making this determination.

- **Note:** The continuation of treatment period for Members who are pregnant and undergoing a course of treatment for the pregnancy, as of the date the notice of termination or pending termination was provided by UPMC Health Plan, shall extend through the postpartum period.

  - **See:** ***Practitioner and Facility Contracting,*** UPMC Health Plan Behavioral Health Services, Chapter L.

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Referral Assistance Given to Members in Selecting Behavioral Health Providers

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

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

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

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

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

Alert–Changing Behavioral Health Provider
Members may ask to change their behavioral health provider **at any time.**

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Statement of UPMC Health Plan's Policy on Incentives

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

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

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

Clinical Practice Guidelines for Common Behavioral Health Disorders

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

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

- **See:** ***Clinical and Preventive Health Care Guidelines,*** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

- **See:** ***Quality Improvement Program,*** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

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UPMC Health Plan Pharmacy Formulary Information

UPMC Health Plan's Pharmacy Services Department helps to monitor appropriate utilization and manage health care dollars spent on prescription medications as well as the benefit plans for all lines of business.

The department also works with Medical Management to coordinate Member care regarding medications.

For the most current information about the UPMC Health Plan pharmacy formulary and related resources, refer to the UPMC Health Plan website at **upmchealthplan.com/providers/medical/resources/other/pharmacy.aspx.**

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

Member Rights and Responsibilities

All Members of UPMC Health Plan have certain rights and responsibilities. Every staff member and behavioral health provider has the obligation and responsibility to know these rights and responsibilities and to support them in daily operations. Member responsibilities are intended to serve as guidelines to help the Member, provider, and others work cooperatively and effectively for the Member's benefit.

Closer Look at Member Rights and Responsibilities
These guidelines can be found on the UPMC Health Plan website at **upmchealthplan.com/providers/medical/resources/guidelines/quality-assurance.aspx.**

- **See:** ***Provider Rights and Responsibilities,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

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Mental Health Advance Directives

UPMC Health Plan Members Can Ask About Mental Health Advance Directives

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

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

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

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

It is important that UPMC Health Plan Members share their written mental health advance directives with their mental health provider. If they do not share their mental health advance directives with their provider, the provider will not be able to follow them. If the Member or their representative believes that their provider has not handled their mental health advance directives properly, or if they have any other complaints about mental health advance directives, they should follow the standard complaint process.

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About Being a Behavioral Health Network Provider

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

- **Practitioners** in individual or group practice, including:
  - Psychiatrists
  - Addictionologists
  - Developmental-behavioral pediatricians
  - Doctoral- or master's-level licensed clinical psychologists
  - Doctoral- or master's-level clinical psychiatric nurse specialists
  - Doctoral- or master's-level certified registered nurse practitioners
  - Doctoral- or master's-level licensed social workers
  - Other doctoral- or master's-level licensed behavioral health clinicians

- **Facilities** and **Organizations:**
  - Clinics
  - Community mental health centers
  - Hospitals
  - Partial hospitalization programs
  - Residential treatment facilities (RTFs)
  - Other organizations providing behavioral health care services in a community setting

- **Providers:**
  - Denotes information that applies to both practitioners and facilities.

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

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Key Points

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

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

Practitioner Credentialing, Contracting, and Recredentialing

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

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

Closer Look at Recredentialing

Behavioral Health Practitioners **must** be recredentialed **every three years.**

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Practitioner Credentialing Process

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

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

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

Key Points

The practitioner credentialing process involves **three** major steps:

- Each credential (degrees, certifications, and licenses) is verified by Community Care's Credentialing Department with primary sources (academic institution, certifying body, licensing board or agency, etc.).

- The initial practitioner credentialing applications and facility assessment/reassessment applications, which includes all credentials verified with primary sources, site visit(s) if necessary, and review of treatment record keeping practices completed satisfactorily, if necessary, **must** be reviewed and approved **within 180 days of the date the attestation was signed.** If not, the application **must** be refreshed with Community Care by returning a copy of the original application with a new attestation that the practitioner reviewed for any changes or additions. This application **must** be returned to Community Care with a newly signed and dated attestation.

  Recredentialing practitioner information is gathered through the Council of Affordable Quality Health (CAQH) database. A provider's attestation **within** the CAQH database is valid for **180 days**, so providers **must** ensure that information in the CAQH database is regularly attested to.

- All criteria **must** be met and verified to consider the application complete for credentialing.

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Alert–Department of Human Service Provider Enrollment

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

➢ **See:** ***Provider Enrollment,*** UPMC Health Plan Provider Manual, Chapter D, UPMC *for Kids* (CHIP).

Practitioners have the following rights during the credentialing process:

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

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

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

Change in Practitioner Information

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

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

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Community Care will send **Practitioner Attachment A form** to be completed and returned so that all applicable departments can be **notified** of the change. Changes are **not** effective until all necessary information has been returned by the provider.

Closer Look at Adding or Changing a Service or Site

Providers are required to log into the Community Care ePortal **at a minimum on a quarterly basis** and validate their name, address, specialty, phone number, digital contact information and currently contracted services at each location. Validation is a regulatory requirement to ensure accuracy of directory information. Failure to validate may result in provider information not being published in Community Care's directory.

- **Note:** The process of validating practitioner information and currently contracted services/locations does not provide an opportunity for changing services and/or service locations. Notification of changes to services and/or service locations should be made **no less than 30 days prior** to the planned effective date of those changes. If a practitioner change involves **adding** or **changing** a contracted service or a site where services are provided to UPMC Health Plan Members, the addition or change **must** meet recredentialing standards **before** payment for services can be processed.

- **Note:** Contracts are service location specific, so services provided to UPMC Health Plan Members may only be rendered at those locations where the provider holds a current contract and when applicable an active PROMISe™ enrollment.

Closer Look at Provider PROMISe™ Enrollment Requirements

All providers who render, order, refer, or prescribe items or services to a Member with Medical Assistance **are required** to have a valid PROMISe™ ID (also known as MMIS Provider ID) with the Commonwealth of Pennsylvania. PROMISe™ IDs correspond to both the provider and location. Thus, the provider **must** register an ID for each location at which he or she provides services to individuals with Medical Assistance coverage. If the provider participates with multiple managed care organizations, the provider is only required to enroll **once per service location.** If a claim is denied due to the lack of a PROMISe™ ID, the provider **may not balance bill** the Member. If there are any questions or issues with the enrollment process, contact the **Department of Human Services' Provider Enrollment Hotline** at **1-800-537-8862, select option 2, then option 4. Finally, choose option 2** to speak to a representative. DHS requires that all providers re-enroll **at least every five years** by submitting a fully completed Pennsylvania PROMISe™ Provider Enrollment Application for every active and current service location. The provider may revalidate a PROMISe™ ID by accessing the following website: **provider.enrollment.dpw.state.pa.us.**

- **See:** UPMC Health Plan Provider Manual, ***Chapter B,*** for additional information.

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Practitioner Contracting

A behavioral health practitioner may begin the contracting process after the practitioner completes the credentialing process with Community Care. Community Care seeks to contract with specific practitioners to provide specific behavioral health services at specific sites to meet the needs of UPMC Health Plan Members.

Criteria considered for contracting include:

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

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

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

If the behavioral health practitioner's contract is terminated, affected UPMC Health Plan Members may be allowed up to **90 days** to continue to be cared for by that particular behavioral health practitioner unless the contract was discontinued as a result of a professional review action, refusal of the practitioner to continue to treat the Member, or else the practitioner is no longer willing to accept the agreed upon terms or payment.

Alert–A request for an extension **up to 90 days <u>does not apply</u>** to UPMC *for Kids.* UPMC *for Kids* Members have a transition period **up to 60 days.**

- **Note:** The transitional period **may be** extended by UPMC Health Plan if an extension is determined to be clinically appropriate. UPMC Health Plan will consult with the Member and the practitioner in making this determination.

- **Note:** The continuation of treatment period for Members who are pregnant and undergoing a course of treatment for the pregnancy, as of the date the notice of termination or pending terminations was provided by UPMC Health Plan, shall extend through the postpartum period.

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Practitioner Initial Credentialing
Behavioral Health providers interested in becoming a UPMC Health Plan provider **should** submit a network participation request online at **upmchealthplan.com/providers/medical/join-us/** or by calling **Community Care Network Management** at **1-888-251-2224.** If the request is approved an application will be sent to the provider. The provider **must** fill in all requested information, sign, and date the attestation, and return it with any requested documents for initial processing to their assigned provider relations representative.

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

- Primary source verification of the practitioner's credentials (any new degrees or certifications, etc., since the time of the last credentialing or recredentialing date, verification of current licensures, malpractice and claims history, etc.)

  - **Note:** Behavioral health practitioners **cannot** be contracted until credentialing has been approved. Services to UPMC Health Plan Members are **not** eligible for reimbursement until both credentialing and contracting has been completed. UPMC Health Plan Members seeking treatment prior to the effective contract date should be referred to an established in-network provider.

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

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

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

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

Practitioner Recredentialing

Behavioral health practitioners **must** be recredentialed **at a maximum of every three years** from the date of initial credentialing or last recredentialing date. Community Care will notify behavioral health practitioners electronically in advance when it is time to start the recredentialing process, which utilizes the Council of Affordable Quality Health (CAQH) database. This review includes verification of provider credentials with the additional consideration of quality information supplied by the Quality Improvement Department.

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

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

All Practitioners Must Be Recredentialed Before Their Expiration Date.

Failure to be recredentialed before the expiration date will result in termination of the practitioner's contract with Community Care and will prevent payment for any services provided after the expiration date. It is the practitioner's responsibility to ensure that Community Care has the most **accurate and current email address** by which to contact them to begin the recredentialing process. A behavioral health practitioner whose credentials with Community Care have expired **cannot** be authorized or paid for services provided after the expiration date.

Alert – Verifying Credentials

Because verifying credentials with primary sources requires time to complete, Community Care notifies practitioners to begin this process in advance of their credentialing expiration date.

Practitioners should ensure that their CAQH profile is accurate, up to date, has a valid attestation, and that Community Care has been granted permission to view their information within the CAQH database. Community Care's credentialing department will reach out to any providers who have not completed these actions during the recredentialing cycle. However, completing the recredentialing process remains the practitioner's responsibility.

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

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

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

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Regarding Files of Provider Information Maintained at Community Care Behavioral Health

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

Written requests should be submitted to:

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

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

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

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Facility/Organization Assessment, Contracting, and Reassessment

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

Closer Look at Reassessment

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

Facility/Organization Assessment

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

The facility assessment process involves four major steps:

- Credentialing staff confirms the facility's licensure and facility's accreditation, if any, and status or standing of the facility with state regulatory bodies.

- In lieu of Community Care doing a site visit, Community Care will accept the facility's current Centers for Medicare & Medicaid Services (CMS) or state review report and any corrective action related to the review.

- Each location where the facility will offer behavioral health services to UPMC Health Plan Members **must** pass a site visit unless the facility has a current accreditation by The Joint Commission, Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA). If, after assessment, a facility adds a location where behavioral health services are to be provided and the new location has not been reviewed, a site visit may be conducted on this new location, unless a copy of the facility's current CMS or state review report and any corrective action related to the review is received or verification that this site is included in the accreditation.

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

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

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

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

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

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

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

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  Credentialing Department
  Suite 1300
  339 Sixth Ave.
  Pittsburgh, PA 15222

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Change in Facility Information

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

To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to UPMC Health Plan Members, facilities are asked to call the **Community Care provider line** at **1-888-251-2224** with **any change** to facility information **at least 30 days prior** to making any such changes. Representatives are available **24 hours a day, 7 days a week, 365 days a year.** Once received, additional information may be requested by a Community Care provider relations representative. If necessary, Community Care will send a facility Attachment A form to be completed and returned so that all applicable departments can be notified of the change.

Alert – Facility Changes

Facilities are required to log into the **Community Care ePortal** at **ccbh.com** **at a minimum on a quarterly basis** and validate their information and currently contracted services at each location. Validation is a regulatory requirement to ensure accuracy of directory information. Failure to validate **may** result in provider information not being published in Community Care's directory.

- **Note:** The process of validating facility information and currently contracted services/locations **does not** provide an opportunity for changing services and/or service locations. Notification of changes to services and/or service locations should be made **no less than 30 days prior** to the planned effective date of those changes. If the facility change involves **adding** or **changing** a contracted service or a site where services are provided to UPMC Health Plan Members, the addition or change **must** be reviewed, and a site visit **may** be required, **before** payment for services can be processed.

- **Note:** Contracts are service location specific, so services provided to UPMC Health Plan Members may only be rendered at those locations where the provider holds a current contract and when applicable an active PROMISe™ enrollment.

  - **See:** ***Closer Look at Provider PROMISe™ Enrollment Requirements*** above for additional information.

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Facility Contracting

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

Criteria considered for contracting include:

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

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

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

For any facility terminated from the network, **up to a 90-day** transition of care period—for routine ambulatory services only—may be initiated for UPMC Health Plan Members under that facility's care.

Alert–A request for an extension up to **90 days does not apply** to UPMC *for Kids.* UPMC *for Kids* Members have a transition period **up to 60 days.**

Facility Reassessment

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

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

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

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All Facilities Must Be Reassessed Before Their Expiration Date
Failure to be reassessed before the expiration date will result in termination of the facility's contract with Community Care and will prevent payment for any services provided after the expiration date.

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

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

Alert – Verifying Credentials

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

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

Facilities have the following rights during the reassessment process:

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

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

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Termination of Provider from the Behavioral Health Network

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

Termination Without Cause

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

Termination with Cause

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

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

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

Notification and Process to Appeal Adverse Determinations Regarding Network Participation

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

The appeal process, if applicable, is as follows:

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

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Record Keeping Standards

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

Each Member's medical record must meet the following standards:

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

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

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

Alert – Record Keeping Expectations

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

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

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

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

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

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

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

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

> ➢ **Note:** The performance goal for completeness of treatment record documentation is **86 percent.**

Adverse Event Reporting (to Protect Patient Safety)

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

Adverse events include, but are not limited to:

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

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

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

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

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

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

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Provider Cultural Competency

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

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

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

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

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

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

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

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Provider Performance Tracking

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

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

➢ **See:** ***Provider Performance Tracking***, UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

Provider Satisfaction

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

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

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

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

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

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

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Provider Disputes

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

- **See:** ***Provider Disputes,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

Provider Education

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

Provider Advisory Committee

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

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

Other opportunities exist to join other Community Care and UPMC Health Plan committees that include behavioral health providers. Call **UPMC Health Plan BHS** at **1-866-441-4185** for information about participating on the committee. Representatives are available **24 hours a day, 7 days a week, 365 days a year.**

New Technology

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

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

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Behavioral Health Case Management and Coaching Support

Availability of Behavioral Health Case Management and Coaching Support

UPMC Health Plan offers behavioral health case management and coaching support to **Commercial** and **Medicare** Members. UPMC Health Plan offers:

- A **depression program** for Members who need support managing their depression.
- An **attention deficit hyperactivity disorder (ADHD) program** to help parents better understand and manage their child's ADHD.
- An **anxiety program** for Members who need support managing their anxiety.
- A **substance use disorder program** for Members who need support managing substance use issues.
- A **case management program** to help Members with behavioral health needs connect to treatment or other resources. The program also coordinates the transition of care to help members recently discharged from an inpatient behavioral health level of care stay connected to treatment.
- A **pain management program** for Members who need support managing chronic pain.
- A **grief program** for Members who can benefit from grief education and support.

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

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

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

➢ **See:** UPMC Health Plan Provider Manual, Chapter D, UPMC *for Kids* (CHIP), for information about available ***care management programs.***

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Confidentiality and Disclosure Policies

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

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

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

➢ **See:** ***Closer Look at Accessing and Sharing Information,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures, for information on how UPMC Health Plan shares provider-specific information or data.

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Quality Improvement Overview

The quality of health care that UPMC Health Plan Members receive is very important. At UPMC Health Plan, considerable resources are dedicated to improving the health care experience of Members. UPMC Health Plan's quality improvement program is overseen by a Quality Committee of the Board and a variety of quality improvement governance committees including the Quality Physician Advisory Council (QPAC). The QPAC is made up of clinicians—including behavioral health specialists—dedicated to improving quality of care and service to Members.

➢ **See:** ***Quality Improvement Program,*** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

Member Satisfaction

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

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

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

Information About Member Complaint and Grievance Procedures

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

➢ **See:** The following locations for ***Member handbooks or Member guides*** detailing the Member's Complaint and Grievance procedures:

Federal Employees Health Benefits Program (FEHB)	**upmchealthplan.com/fehb/**
UPMC *for Kids* (CHIP) UPMC *for Life* (Medicare) UPMC *for Life* Complete Care (HMO SNP)	**upmchealthplan.com**
UPMC Health Plan (Commercial)	**upmc.widen.net/s/rchsrfzllf/22cg-ind3087504---pod---2023-member-guide-standard-groupind**.

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

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

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Fraud and Abuse Reporting

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

Fraud

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

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

Abuse

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

- Providers billing for unnecessary or excessive services.
- Providers performing a large number of laboratory tests on patients when only one or a few tests were medically necessary.

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

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

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Provider Actions to Avoid Fraud and Abuse

UPMC Health Plan encourages behavioral health providers to read the UPMC Health Plan Provider Manual and/or call **UPMC Health Plan BHS** at **1-866-441-4185** with any questions about standards of care, documentation and record keeping, claims/billing procedures, or any other activity that could be associated with a fraud or abuse concern. Representatives are available **24 hours a day, 7 days a week, 365 days a year.**

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

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

UPMC Health Plan Claims Procedures

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

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

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

Contact the **UPMC Health Plan Provider Services Department** at **1-866-918-1595,** Monday through Friday from 8 a.m. to 5 p.m., with any questions regarding claims.

Contact the **UPMC Health Plan Electronic Data Interchange department** at **HealthPlanEDI@upmc.edu,** Monday through Friday, from 8 a.m. to 5 p.m., for EDI customer support and technical assistance.

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