UPMC Community HealthChoices (Medical Assistance)

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At a Glance

UPMC Community HealthChoices is a Medical Assistance product offered by UPMC *for You*, an affiliate of UPMC Health Plan. UPMC Community HealthChoices offers coverage of high-quality care to eligible Medical Assistance recipients in the Commonwealth of Pennsylvania. Eligible recipients are those who are **21 years old and older** and are either:

- Eligible for Long-Term Services and Supports (LTSS) or
- Eligible for both Medical Assistance and Medicare.

UPMC Community HealthChoices, as **one of three** state-wide Managed Care Organizations (MCOs) for the Commonwealth's Community HealthChoices (CHC) program, offers coverage for medical care and Long-Term Services and Supports (LTSS) to its Members (also called "Participants"). LTSS coverage is only provided to Participants who are clinically eligible to receive LTSS, in that they require the level of care that would be provided in a nursing facility. UPMC Community HealthChoices includes a vast network of medical and LTSS service providers.

All UPMC Community HealthChoices providers **must** abide by the applicable rules and regulations set forth under the Commonwealth of Pennsylvania Medical Assistance Manual, 55 Pa. Code, chapters 1101–1251, the requirements of Pennsylvania's §1915(c) Home and Community-Based Services Waiver, and the Community HealthChoices (CHC) Agreements between the Pennsylvania Department of Human Services (DHS) and the MCOs. The Waiver documents and Community HealthChoices Agreement are available at **dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Supporting-Documents.aspx.**

Alert—Department of Human Services Regulations

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

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

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

Community HealthChoices Managed Care in Pennsylvania

UPMC Community HealthChoices provides **at least** the same level of medical coverage offered by Pennsylvania's Medical Assistance Adult Benefit Package. For individuals eligible for LTSS, UPMC Community HealthChoices also provides at least the level of service coverage set forth in Pennsylvania's §1915(c) Home and Community-Based Services Waiver.

Behavioral health coverage **is not** included in UPMC Community HealthChoices. Behavioral Health coverage is provided by behavioral health managed care organizations (BH-MCOs) that separately contract with DHS and operate at the county level.

Eligible Medical Assistance recipients can enroll in a Community HealthChoices MCO or change plans with the assistance of an independent enrollment broker. Recipients **may** call the **Independent Enrollment Broker** at **1-844-824-3655 (TTY: 711)** or visit **paieb.com/en.**

Population Served

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

- Receive Medical Assistance and LTSS because their identified needs make them nursing facility clinically eligible; or
- Receive Medicare and Medical Assistance (dual eligible).

Individuals are not eligible for UPMC Community HealthChoices if they are:

- Receiving LTSS in the OBRA Waiver program but **are not** nursing facility clinically eligible; or
- Participating in the Attendant Care Waiver (Act 150) Program but **are not** dually eligible for Medicare and Medical Assistance; or
- An individual with an intellectual disability or autism who is receiving services through the DHS Office of Developmental Programs beyond supports coordination; or
- A resident in a state-operated nursing facility, including the state veterans' homes.

Closer Look at the Community HealthChoices population

Participants dual eligible for Medicare and Medical Assistance:

- Participants have **two distinct plans**—a Medicare plan and a Community HealthChoices (Medical Assistance) plan. Medicare provides primary medical coverage, and Community HealthChoices provides secondary medical coverage, plus LTSS coverage if eligible.
    - Participants **may** choose UPMC Community HealthChoices as their Medical Assistance Plan and choose UPMC Health Plan for their Medicare coverage (UPMC *for Life* Complete Care [HMO D-SNP] or UPMC *for Life* Medicare [Advantage Plan]).
    - Participants **may** choose UPMC Community HealthChoices as their Medical Assistance plan but choose another insurer that is not UPMC Health Plan (including Original Medicare) for their Medicare coverage.
- Participants **may or may not** be eligible to receive LTSS. LTSS-eligible Participants **may** reside in a long-term nursing facility or in the community and will have access to services and supports not generally covered by traditional Medicare or Medical Assistance physical health coverage. For LTSS-eligible Participants, UPMC Community HealthChoices will provide coverage for LTSS benefits.

➢ **See:** ***Covered Benefits,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

➢ **Note:** Physical health (medical) providers **do not need** to be in UPMC Community HealthChoices' network to provide Medicare-covered services to dual-eligible Participants. Medicare providers can continue to see their patients and receive Medicare reimbursement. UPMC Community HealthChoices will provide secondary coverage for these services when applicable.

➢ **See:** ***Coordination between Medicare and UPMC Community HealthChoices,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Participants eligible for Medical Assistance/LTSS only:

- Participants will have **one plan** that covers medical and LTSS benefits.
- All Participants will be eligible to receive LTSS. Participants **may** reside in a long-term nursing facility or in the community, and will have access to services and supports **not** generally covered by traditional Medicare or Medical Assistance physical health coverage.

  ➢ **See:** ***Covered Benefits,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

- Physical health (medical) providers **must be** in UPMC Community HealthChoices' network to provide services to UPMC Community HealthChoices Participants who are eligible as Medical Assistance/LTSS only.

  ➢ **See:** ***Determining Primary Insurance Coverage*** and ***Identifying Member and Verifying Eligibility*** sections of UPMC Health Plan Provider Manual, Chapter I, Member Administration.

Coordination Between Medicare and UPMC Community HealthChoices

For UPMC Community HealthChoices Participants who are dual eligible for Medicare and Medical Assistance, Medicare is the primary payer and UPMC Community HealthChoices is the secondary payer. Dual-eligible Participants **should** receive Medicare-covered services from Medicare providers in their Medicare plan's network. Participants can choose any Medicare plan and any Medicare provider that participates with their plan. UPMC Community HealthChoices works with all Medicare providers and plans to coordinate services. When providing Medicare-covered services, Medicare providers **do not** need to be in UPMC Community HealthChoices' network. After Medicare pays primary, UPMC Community HealthChoices will decide if it needs to pay the provider secondary.

UPMC Community HealthChoices **only** pays primary for covered services if the service is **not** covered by Medicare or Medicare benefits have been exhausted. In these cases, the provider **must** be in the UPMC Community HealthChoices provider network.

➢ **See:** ***Medical Assistance Revalidation Requirement,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

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

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

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

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

Covered Benefits

At a Glance

UPMC Community HealthChoices covers medically necessary services that include, but are **not limited to,** coverage provided by the DHS Medical Assistance Adult Benefit Package and §1915(c) Home and Community-Based Services Waiver Programs.

> ➢ **Note:** §1915(c) Home and Community-Based Services **are only covered** for participants who are eligible for LTSS.

UPMC Community HealthChoices in-network providers provide a variety of medical and LTSS services, some of which are itemized on the following pages. For specific information **not covered** in this manual, call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

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

Table N1: UPMC Community HealthChoices Covered Physical Health Services (cont'd)
Prescribed Drugs
Prescribed prosthetic devices
Primary Care Services
Radiology (X-rays, MRIs, CTs)
Renal Dialysis Services
Rural Health Clinic
Short Procedure Unit (Outpatient Hospital)
Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of DHS
An abortion is a covered service only when a physician has found, and certified in writing, that on the basis of that physician's professional judgment, the life of the mother would be endangered if the fetus was carried to term, in accordance with 42 CFR 441.200 *et seq*.
Definitions for Physical Health Services **may** be found in the Pennsylvania Medicaid State Plan at **dhs.pa.gov/docs/Publications/Pages/Medicaid-state-plan.aspx.**

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

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

> **Note:** Some services are included on both the UPMC Community HealthChoices covered Physical Health Services list and the UPMC Community HealthChoices covered Home and Community-Based Services list. Requests for authorization of these services will be reviewed through coordination between UPMC Health Plan's Utilization Management and Service Coordination department. Home and Community-Based Services **will be** covered as part of a Participant's LTSS benefits **only if** the Participant's primary medical coverage (e.g., Medicare or private insurance) **does not cover** the services in question or if service limitations have been reached.

Definitions for the LTSS services listed above can be found in the §1915(c) Home and Community-Based Services Waiver, as **may** be amended from time to time at **dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Supporting-Documents.aspx.**

> **Note:** Definitions are found in the most recent version of the §1915(c) Waiver Document on that page.

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

Coverage can be verified at **upmchealthplan.com/providers** or by contacting **Provider Services** at **1-844-860-9303,** from 8 a.m. to 5 p.m. Monday through Friday.

➢ **Note:** When a Participant transfers assets for less than fair market value during the look-back period for Medical Assistance eligibility, the Participant is subject to a period of ineligibility for payment of Nursing Facility services and Home and Community Based Services, known as a **"penalty period."** To maintain compliance with the federal and state rules regarding penalty periods, UPMC Community HealthChoices **cannot pay** Nursing Facility or Home and Community-Based Services claims for Participants who are subject to a penalty period. Claims for Nursing Facility or Home and Community-Based Service during the penalty period **will be denied.** Participants are responsible to pay for Nursing Facility or Home and Community-Based Services until their penalty period has ended. Providers **must** collect payment for Nursing Facility or Home and Community-Based Services provided during the penalty period directly from the Participant. UPMC Community HealthChoices may recoup payments for Nursing Facility or Home and Community-Based Services made in error to the provider during the Participant's penalty period.

Coordinated Care

If a Participant has Medicare, Medicare-covered care **should** be coordinated with providers in the Participant's Medicare network, according to the Medicare plan's rules and policies. For Participants who **do not** have Medicare, the Participant's UPMC Community HealthChoices participating primary care provider (PCP) **must** coordinate care. Participants **may** self-direct their care for routine gynecological examinations, family planning, maternity care or prenatal visits, dental care, vision care, and Indian health care providers. If the PCP refers a Participant to an in-network specialist and indicates a need for diagnostic testing, the Participant **should** be directed to an in-network provider for that testing. A separate referral by the specialist **is not** required. When needed, a Participant can seek a second opinion from a qualified provider within the network at **no cost** to the Participant. If a qualified Provider **is not** available within the network, the Participant will receive assistance in obtaining a second opinion from a qualified provider outside the network, **at no cost** to the Participant, unless copayments apply.

Upon notification by the Participant, family member, Participant's legal designee, or a hospital emergency department, the Participant's PCP **must** coordinate any care related to an emergency.

➢ **Note:** With approval from the Participant, UPMC Health Plan will provide the PCP, other health care provider(s), and home- and community-based service provider(s) that support the Participant's life in the community access to most of the Participant's Person-Centered Service Care Plan details. The care plan can be found through **Provider OnLine** at **upmchealthplan.com/providers.** It is the responsibility of the provider to access this information as needed **(and only as needed)** to enhance the coordination or quality of care.

All payments made to providers by UPMC Community HealthChoices constitute full reimbursement to the provider for covered services rendered.

➢ **See:** The ***provider's contract*** for specific fee schedules.

If UPMC Community HealthChoices imposes copayments for certain covered services and a Participant **cannot** afford to pay the copayment, providers **must** render covered services to the Participant despite nonpayment of the copayment by the Participant. This **shall not** preclude providers from seeking payment for the copayments from Participants after rendering covered services.

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

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

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

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

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

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

  ➢ **See:** Additional ***Appointment Standards*** in the charts below.

  ➢ **Note:** The following information is provided to the Participants in the Participant Handbook. **Instances of "you" refer to the Participant.**

Table: N.4: New Participants

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

Table N.5: Ob-gyn and PCPs	
Emergency	**Must** be seen **immediately** or referred to an emergency room.
Nonurgent Sick Visits	**Within 72 hours** of request.
Routine care	**Must** be scheduled **within 10 business days** of request.
Urgent medical conditions	**Must** be scheduled **within 24 hours** of request.
Wellness (physical, wellness exam, well-child exam)	**Must** be scheduled **within three weeks** of request.
Well-woman exams	**Must** be scheduled **within three weeks** of request.
If Participant reports to the Emergency Department but does not require or	**Promptly.**
Maternity care	Initial prenatal care appointments **must** be scheduled: • **First** trimester – **Within 10 business days** of request • **Second** trimester – **Within five business days** of request • **Third** trimester – **Within four business days** of request High-risk pregnancies – **Within 24 hours** of notifying the provider of the high risk, or immediately, if an emergency exists.

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

Table N.6: Specialists	
Emergency cases	**Must** be seen **immediately** or referred to an emergency room
Urgent medical conditions	**Must** be scheduled within **24 hours** of request
Routine care	**Must** be scheduled within **15 business days** of request for the following specialty providers: • Dentist • Dermatology • Orthopedic Surgery • Otolaryngology **Must** be scheduled **within 10 business days of request for all other** specialty providers

Service Descriptions

This section includes important information about frequently used services. For more information about these or other covered services, contact **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

- **Note: Many services require prior authorization,** even if that requirement **is not** specifically identified below**.**

When prior authorization is required, the in-network provider **must** contact **Utilization Management** for a prior authorization review of medical necessity. Providers **must** request prior authorization by submitting a completed UPMC Health Plan medical necessity form and/or a Letter of Medical Necessity, and all relevant clinical and social information through **Provider OnLine** at **upmchealthplan.com/providers.**

Out-of-network providers **must** contact **Utilization Management** at **1-800-425-7800.** Medical necessity forms and instructions for submitting authorization requests can be found at **upmchealthplan.com/providers/forms.** Failure to obtain authorization will result in denial of the claim.

If written information is required, it **may** be sent to:

UPMC Health Plan
Utilization Management Department
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

- **Note:** Certain benefit categories **may** include specific services that are **not** on the Medical Assistance fee schedule. These services can be requested as a Program Exception.

- **See:** ***Prior Authorization*****,** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

- **See:** ***Program Exception Process*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Behavioral Health and Substance Use Disorders Benefits

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

Commonly available **Behavioral Health treatment** services include outpatient therapy and psychiatry, partial day/partial hospitalization programs, inpatient hospitalization, and community-based services such as mobile psychiatric rehabilitation and targeted case management services, among others. Commonly available **substance use disorders treatment** services include **24-hour** care and rehabilitation in a hospital or nonhospital setting, services for detoxification from alcohol or other drugs, outpatient services for substance use disorder treatment, peer-delivered support services, and crisis services as needed. Also included are medication-assisted treatment for substance use disorders, for example: methadone maintenance or suboxone treatment.

To refer for behavioral health and substance use disorder treatment, providers can directly contact the BH-MCO in the Participant's county. Upon referral, the BH-MCO will coordinate appropriate appointments and/or treatment plans with providers based on specific behavioral health and substance use disorder treatment needs and conditions.

Some behavioral health services **may** require coordination with a Participant's Home and Community-Based Services. Behavioral health providers needing to coordinate behavioral health care and LTSS **must** contact the **Service Coordination department** at **1-833-280-8508 (TTY: 711).** Representatives are available from 8 a.m. to 5 p.m. Monday through Friday.

> ➢ **See:** ***Table A.2, for a list of BH-MCOs, UPMC Community HealthChoices (Medical Assistance Contacts),*** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

Chiropractic Care

UPMC Community HealthChoices Participants **may** self-direct to chiropractic care. Chiropractic services are covered when medically necessary and delivered by an in-network provider.

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

Dental Care

UPMC Community HealthChoices Participants have access to certain dental services. UPMC Community HealthChoices Dental *Advantage* administers routine dental benefits, including prior authorization and medical necessity reviews for UPMC Community HealthChoices Participants. Participants **may** self-direct their dental care to an in-network provider.

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

> ➢ **See: UPMC Community HealthChoices Dental *Advantage* section of the *Dental Provider Manual*** for full details of the dental prior authorization process at **upmchealthplan.com/providers/dental/skygen/default.aspx.**

There are differences in benefits and limits for Participants who are eligible for LTSS and Participants who are **not** eligible for LTSS.

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

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

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

➢ **See:** ***Table N7: Dental Limits,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

➢ **See:** ***Program Exception Process***, UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Table N7 Dental Limits Description	Full Benefits	
	NOT RESIDING in a Nursing Facility AND NOT eligible for HCBS	**RESIDING** long-term in a Nursing Facility OR eligible for HCBS
Anesthesia	**Covered** **May** require prior authorization or be subject to post payment review	**Covered** **May** require prior authorization or be subject to post payment review
Checkups *-Routine exam, including X-rays*	**Covered – 1 per 180 days** Additional exams require a BLE	**Covered**
Cleanings *-Prophylaxis*	**Covered – 1 per 180 days** Additional cleanings require a BLE	**Covered**
Crowns and adjunctive services	**Not Covered** Unless a BLE is approved	**Covered** Requires prior authorization
Dentures* *-**One** partial upper denture or **one** full upper denture and **one** partial lower denture or **one** full lower denture.*	**Covered – Once per lifetime** Requires prior authorization Additional dentures require a BLE	**Covered – Once per lifetime** Requires prior authorization Additional dentures require a BLE
Dental surgical procedures	**Covered** Requires prior authorization	**Covered** Requires prior authorization
Dental emergencies *-Emergency care*	**Covered**	**Covered**
Extractions *-Impacted tooth removal*	**Covered** Requires prior authorization	**Covered** Requires prior authorization
Extractions *-Simple tooth removal*	**Covered**	**Covered**
Fillings *-Restorations*	**Covered**	**Covered**
Orthodontics** *-Braces*	**Not Covered****	**Not Covered****
Palliative care *-Emergency treatment of dental pain*	**Covered**	**Covered**
Periodontal & endodontic services	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
Root canals	**Not covered** Unless a BLE is approved	**Covered** Requires prior authorization
X-rays	**Covered**	**Covered**
Inpatient hospital, Short Procedure Unit (SPU), or Ambulatory Surgical Center (ASC) dental care*	**Covered** Requires prior authorization	**Covered** Requires prior authorization

➢ **Note: BLE = Benefit Limit Exception**

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

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

***Requests will be reviewed for medical necessity. Reasons for medically necessary dental care in a facility or ASC include:

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

Diagnostic Services

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

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

➢ **See:** ***Behavioral Health and Substance Use Disorders Benefits*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

➢ **See:** ***UPMC Community HealthChoices Behavioral Health Services – Table A2,*** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

Closer Look at Laboratory Services

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

There are several different types of CLIA certifications:

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

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

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

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

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

➢ **See:** ***DHS Quick Tip #153*** at **dhs.pa.gov/providers/Quick-Tips/Documents/Qtip%20153.pdf.**

Emergency Care

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

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

Closer Look at Emergency Care

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

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

Redirected Emergency Department Visit

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

Alert - Redirected Emergency Department Visit

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

Hearing Exams/Aids

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

Home Health Care

Home health care services are covered when coordinated through an in-network provider. The following services **may** require prior authorization either at the outset or after a set number of visits, as outlined in UPMC Health Plan's Medical Policies and Procedures:

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

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

➢ **See:** ***Covered Benefits***, UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Home Medical Equipment (HME)

Medically necessary home medical equipment (e.g., hospital beds, manual wheelchairs, walkers, or respiratory equipment including oxygen therapy) is covered when coordinated through an in-network provider.

Specialized Home Medical Equipment (SHME)

Medically necessary specialized home medical equipment, including **but not limited** to power mobility devices (e.g., power wheelchairs and scooters), pressure reducing support surfaces, lymphedema pumps, and bone growth stimulators, is covered when coordinated through an in-network provider. SHME requires a prior authorization review.

If Specialized Home Medical equipment needs exceed standard benefit coverage, Participants who are eligible for LTSS **may** qualify to receive additional medical equipment benefits.

➢ **See:** ***Covered Benefits*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Home Physician Visits

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

Hospice Care

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

Hospital Admissions

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

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

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

Immunizations

UPMC Community HealthChoices covers certain adult immunizations. Call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday for more information.

Nursing Facility Services

If a UPMC Community HealthChoices Participant enters a Nursing Facility (NF), UPMC Community HealthChoices covers **up to** the **first 30 days of care** (including hospital reserve bed days and therapeutic leave days) via the participant's physical health (medical) benefit, after any applicable Medicare benefits have been exhausted.*

UPMC Community HealthChoices only covers NF stays **more than 30 days** for Participants who are eligible for long-term services and supports (LTSS) by being Nursing Facility Clinically Eligible (NFCE).

If a Participant is Nursing Facility Ineligible (NFI) and **does not** have a LTSS benefit, UPMC Community HealthChoices will **not pay for days past day 30.*** It is the NF's responsibility to assist a NFI Participant through the eligibility process for LTSS. If a NFI Participant is found eligible for LTSS, the NF can bill UPMC Community HealthChoices for providing services **beyond 30 days** beginning with their **first day** of LTSS eligibility.

> ➢ **Note:** *NFs are required to request authorization for services for **all new 30-day** stays for UPMC Community HealthChoices Nursing Facility Ineligible (NFI) Participants.

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

Coverage for Participants who are NFI (have **not** been determined NFCE/eligible for LTSS as of their admission date) is as follows:

If a resident is already a UPMC Community HealthChoices Participant:

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

- When the resident is determined to be NFCE/eligible for LTSS, the NF can bill UPMC Community HealthChoices for providing services **beyond 30 days** beginning with their **first day** of LTSS eligibility.

NFs **must** notify **Utilization Management** at **1-800-425-7800** if a UPMC Community HealthChoices Participant has remained in the nursing facility **past 30 days without** being determined NFCE/eligible for LTSS.

If a resident is enrolled in a HealthChoices MCO (PH-MCO) and transitions to UPMC Community HealthChoices:

- The PH-MCO (HealthChoices) will pay for **days 1–30.**

- The PH-MCO (HealthChoices) will pay for **day 31 up to the date of the NFCE/LTSS eligibility determination, subject to the rules below.**

- When the resident is determined NFCE/eligible for LTSS, the NF can bill UPMC Community HealthChoices for providing services **beyond 30 days** beginning with their **first day** of LTSS eligibility.

> ➢ **Note:** If a resident is subject to a spend-down period, the PH-MCO **will not** be responsible to pay the NF benefits **after day 30.** The PH-MCO continues to be responsible for all other HealthChoices-covered services **after day 30.** It is acceptable for the PH-MCO to decline to pay NF claims for **days after day 30** until notice is received that the resident's spend down requirement has been met.

For residents enrolled in UPMC *for You* (Medical Assistance), NFs **must** notify **Utilization Management** at **1-800-425-7800** if a resident has remained in the nursing facility past **30 days** without being NFCE/eligible for LTSS.

➢ **Note:** If a resident is found to be ineligible for LTSS, the resident is responsible to private pay for any days beyond the **30 days** covered by the CHC-MCO or PH-MCO.

Prior Authorization Requests
Prior authorization requests for Nursing Facility services are submitted through **Provider OnLine** at **upmchealthplan.com/providers.**

➢ **See:** ***Provider OnLine*****,** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

➢ **See:** ***How to Contact or Notify Utilization Management*****,** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

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

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

- Therapeutic Days:
  - A **maximum** of **30 days per calendar year** will be reimbursed at the **then current per diem rate.**

- Hospice Days
  - NF will be reimbursed for Hospice Days at the **then current per diem rate.**
  - The Hospice provider will be reimbursed for Hospice Services directly.

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

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

➢ **Note:** Continuity of Care **does not** apply for a NF provider terminated from the UPMC Community HealthChoices network for cause per the provider's UPMC Health Plan Ancillary Provider Agreement.

Respite Stays

Respite care is temporary care for a NFCE community-based Participant. Respite care typically takes the place of direct care provided by informal caregivers. Whether planned or unplanned, respite care **may** last a **few hours to a few weeks** depending on needs of the caregiver. If the need for respite care is requested in a nursing facility, the stay **may only last 14 consecutive days per year,** but can be increased up to **29 consecutive days,** with prior approval. The prior approval is given by the UPMC Community HealthChoices assigned Service Coordinator for that facility. Respite days are reimbursed at the then **current per diem rate** and are billed using the **Revenue Code (0100).** For more information, call the **UPMC Community HealthChoices Service Coordination Department** at **1-833-280-8508** (**TTY:711),** Monday through Friday from 8 a.m. to 5 p.m.

Office Visits

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

Closer Look at Referrals

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

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

Organ Transplants

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

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

Routine care performed by out-of-network providers **is not covered** for UPMC Community HealthChoices Participants. Care for an emergency medical condition, provided by an out-of-network provider, is covered. Participants are encouraged to notify their PCPs after they receive such care.

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

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

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

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

Participants who receive LTSS **may** be eligible to receive out-of-area LTSS services when traveling. The Provider or Participant **should** contact the **Service Coordination Department** at **1-833-280-8508 (TTY: 711)** for prior authorization. Representatives are available from 8 a.m. to 5 p.m. Monday through Friday.

Alert – Out-of-Network Care Referrals

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

UPMC Health Plan
Utilization Management Department
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

Alert–Out-of-Area Services

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

Outpatient Surgery

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

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

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

➢ **See:** ***UPMC Community HealthChoices Pharmacy Program***, UPMC Health Plan Provider Manual, Chapter J, Pharmacy Services.

Prosthetics and Orthotics
Prosthetic and orthotic services **must be** coordinated through an in-network provider.

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

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

Rehabilitative Therapy

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

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

➢ **Note:** Certain therapies **may** require authorization after a standard number of visits.

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

➢ **See:** ***Covered Benefits***, UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Reproductive Procedures

Abortion

An abortion **may** be covered when the mother's life is in danger or pregnancy is the result of rape or incest. An abortion is covered when a physician certifies that due to a condition, illness, or injury, an abortion is necessary to prevent the death of the woman, which is a medical judgment to be made by the certifying physician. A licensed physician **may** make the certification whether the physician has a pecuniary or proprietary interest in the abortion.

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

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

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

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

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

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

Hysterectomy

A hysterectomy is covered when coordinated through a PCP or ob-gyn provider and performed by an in-network provider. The hysterectomy **must** be medically necessary and performed for a valid reason other than sterilization. A second opinion is **not** required, but the Participant **may** request one through her PCP or ob-gyn provider. The provider and Participant **must** complete a **Patient Acknowledgement for Hysterectomy form (MA-30).** The consent form **must** be maintained in the Participant's medical record and a copy of the form **must** be submitted with the claim.

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

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

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

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

Specialist Care

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

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

Therapy

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

Transportation

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

> ➢ **Note: Air Ambulance**
> Rotary-wing air ambulances are covered in emergency situations when medically necessary. Fixed-wing air ambulances are covered only in extraordinary circumstances and must be requested through the Program Exception process. Providers **must** contact **Utilization Management** at **1-844-849-2926.**

> ➢ **Note: Ambulance Services Onsite No Transport**
> Payment will be made for reasonably necessary costs associated with the provision of emergency services when an emergency medical services agency is dispatched to provide medically necessary emergency care covered by UPMC Community HealthChoices even if the covered Member **does not require** transport **or refuses** to be transported. The payments are subject to all copayments, coinsurances, and deductibles.

> ➢ **See:** ***Ambulance Services Onsite, No Transport*** policy for full details at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.**

Nonemergency Transportation
Participants **should** contact the **DHS Medical Assistance Transportation Program (MATP)** county offices to arrange for nonemergency transportation to and from Medical Assistance-billable (compensable) nonemergency medical services (e.g., from home to the doctor's office for a routine visit). MATP requires **24- to 72-hour** advance notice. If the Participant needs assistance scheduling medical transportation, the **UPMC Community HealthChoices Health Care Concierge team** can be reached **24 hours a day** by calling **1-844-833-0523 (TTY: 711).** UPMC Community HealthChoices Participants with LTSS have Service Coordinators who can also assist Participants to sign up and schedule rides with MATP. For more information about medical transportation, contact **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

> ➢ **Note:** MATP **does not** provide transportation for individuals who require specialized transportation (e.g., individuals requiring transportation by ambulance or on a stretcher). Specialized nonemergency medical transportation **must** be coordinated by the Participant's Service Coordinator. To speak with a Service Coordinator, contact the **Service Coordination Department** at **1-833-280-8508 (TTY:711).** Representatives are available from 8 a.m. to 5 p.m., Monday through Friday.

> ➢ **See:** ***Medical Assistance Transportation Program (MATP) County Offices*****,** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

Transportation for Participants in Nursing Facilities
For UPMC Community HealthChoices Participants residing in Nursing Facilities, nonemergency transportation **must be** coordinated and paid for by the Nursing Facility.

Nonmedical Transportation
Nonmedical Transportation is covered for UPMC Community HealthChoices Participants **only if** it is included on the Participant's Person-Centered Service Plan as a Home and Community-Based Service. For more information or to speak with a Service Coordinator, contact the **Service Coordination Department at 1-833-280-8508 (TTY:711).** Representatives are available from 8 a.m. to 5 p.m., Monday through Friday.

Urgent Care

Urgent care is defined as any illness, injury, or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated **within a 24-hour period** and, if left untreated, could rapidly become an emergency medical condition. Additionally, such services **may** be provided by an out-of-network provider under unusual and extraordinary circumstances within the UPMC Community HealthChoices service area when an in-network provider is temporarily unavailable and when such services are medically necessary and require immediate attention. Urgent care from out-of-network providers is covered when the Participant is temporarily absent from the approved service area.

Closer Look at Urgent Care

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

Vision Benefits (Routine)

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

UPMC Community HealthChoices covers:

- Routine vision exams **twice a year.**
- A **$100 allowance** toward eyeglasses **(one frame and two lenses)** or toward contact lenses and fitting **every 12 months** (from prior service date). If the Participant chooses standard eyeglasses or contact lenses that are within the allowance, there is **no cost** to the Participant. If the cost exceeds the allowance, the Participant will be responsible for any **cost over the $100.**
- Glasses or contact lenses to treat aphakia (medical condition).
- Specialist eye exam with referral from PCP.

Women's Health

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

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

Family Planning
Participants **may** self-direct care to in-network or out-of-network providers and clinics for family planning and birth control services. These services enable individuals to voluntarily determine family size and **should** be available without regard to marital status, age, sex, or parenthood. UPMC Community HealthChoices Participants **may** access, at a minimum, the education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, long-acting reversible contraceptives (LARC) such as intrauterine devices (IUDs) and subdermal contraceptive implants, diaphragms, foams, creams, jellies, condoms (male and female), injectables, and other family planning procedures.

Pregnancy Care
Participants can self-direct care to an in-network ob-gyn provider for maternity care and prenatal visits. The ob-gyn provider **must** notify the Participant's PCP in writing that the Participant is receiving maternity care. UPMC Community HealthChoices offers pregnant women Baby Steps, UPMC Health Plan's maternity program, which provides patient-centered support and education throughout the preconception, prenatal and postpartum period.

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

Closer Look at Maternity Care Manager

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

Participants or providers **may** call **Baby Steps, UPMC Health Plan's maternity program** at **1-866-778-6073 (TTY: 711),** Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Postpartum Care
The postpartum period **(12 months after delivery)** is an extremely important time for the well-being of both the mother and baby. UPMC Community HealthChoices supports the proactive scheduling of the postpartum office visit **between 7 and 84 day**s after the baby's birth. Additionally, UPMC Community pays for postpartum home health visits for UPMC Community HealthChoices participants.

Obstetrical Needs Assessment
Ob-gyns and PCPs performing routine obstetric services **should** complete an **Obstetrical Needs Assessment Form** (OBNA Form or ONAF), which is a comprehensive assessment of the physical, psychological, and obstetrical history of a UPMC Community HealthChoices Participant.

This information is used to identify Participants at risk for complications in pregnancy and who would benefit from enrollment in Baby Steps, UPMC Health Plan's maternity program. Providers **must** include either their four-digit site ID number or their PROMISe™ (MMIS) ID number on the form. To obtain additional information about the provider's site ID number, call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m. Monday through Friday**.**

➢ **Note:** Providers **must** be enrolled in the Medical Assistance program and possess an active PROMISe ID (also known as the MMIS ID) for **each location** at which they provide services.

➢ **See:** ***Closer Look at Provider PROMISe ID Requirements***, UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices.

Closer Look at Obstetrical Needs Assessment Form

Providers **should** complete the OBNA form and submit it electronically to UPMC Health Plan in **Optum OB Care.** For questions about submitting the form electronically, Providers **may** call **Provider Services** at **1-844-860-9303** or **Baby Steps, UPMC Health Plan's maternity program** at **1-866-778-6073 (TTY: 711).**

All OB providers will use the **Optum OB Care** web tool. Providers can get answers to questions about the form or obtain information about using the Optum OB Care web tool by calling **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m., Monday through Friday.

The OBNA **should** be submitted **within 30 days** of the following visit dates:

- The initial visit between **28 and 32 weeks**, and
- Following the postpartum visit **(7–84 days after delivery)**

In addition, the OBNA **should** be updated as applicable for any change in the Participant's OB status [e.g., new diagnosis pregnancy induced hypertension (PIH) or preterm labor (PTL)]. It is important that the dates of all the prenatal visits are included and risk factors are documented.

This information is used to help identify Participants for Baby Steps, UPMC Health Plan's maternity program. If the provider has questions about the form, call **Baby Steps, UPMC Health Plan's maternity program** at **1-866-778-6073 (TTY: 711).**

A blank form, instructions, tip sheet, and depression screening tools can be found on **Provider OnLine** under documents/form, Maternity, Obstetrical Needs Assessment form at **upmchealthplan.com/providers.** The form is also located in the **Physician Forms** section at **upmchealthplan.com/providers/medical/resources/forms/medical-pa.aspx.**

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

Depression Screening Tools

Providers are **required** to screen pregnant Participants for depression, both prenatally and postpartum, using a validated depression screening tool that is applicable for the provider's practice.

➢ **Note:** DHS **does not** endorse a specific screening tool to assess depression.

Forms, example screening tools, and instructions are also available online in the **Resources & Information** section at: **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx**

➢ **See:** ***The Baby Steps Maternity Program*****,** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

➢ **See:** ***Other Resources and Forms*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Closer Look at Provider PROMISe™ ID Requirements

All providers who render, order, refer, or prescribe items or services to UPMC Community HealthChoices Participants 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 they provide services to UPMC Community HealthChoices Participants covered under these programs. If services are provided to a UPMC Community HealthChoices Participant or the provider participates with multiple managed care organizations affiliated with those lines of business, 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** a UPMC Community HealthChoices Participant. 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. Providers **may** also contact their UPMC Health Plan physician account executive.

➢ **See:** ***Medical Assistance Revalidation Requirement,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

Other Services

Other services available to UPMC Community HealthChoices Participants include:

Health Management Programs

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

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

A specialized team of health coaches (nurses, social workers, dietitians, exercise physiologists, counselors, and health educators), in collaboration with the Participants' providers, work to accomplish these goals through Participant education, coordination of care, and timely treatment. In addition, these programs provide help for Participants to manage their chronic illnesses through preventive practices and adherence to their treatment plans. Health management programs also help form connections with community support groups and agencies.

Participants also have access to lifestyle health coaching to help support them in making healthy lifestyle changes. UPMC Health Plan lifestyle health coaches work with participants who have health and wellness goals in the areas of nutrition, physical activity, weight management, stress management, and tobacco cessation.

UPMC Community HealthChoices also offers coaching for pediatric lifestyle needs, including Healthy Families. Participants can work with lifestyle health coaches through weekly sessions or a customized schedule that supports Participants in meeting their goals. Sessions consist of working through barriers to making changes, celebrating success, and setting short- and long-term goals. Health coaches provide support and accountability to participants, and coaching sessions are tailored to each Participant's priorities and needs to help them make the changes needed to live healthier lives. Participants **may** participate through telephonic or virtual sessions, or they can download RxWell (a UPMC Health Plan app) to immediately engage in a digital program. In addition to the areas listed above, RxWell also offers programs in sleep, depression, anxiety, and diabetes.

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

UPMC *My*Health 24/7 Nurse Line

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

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

The Participant **may** call **1-866-918-1591 (TTY: 711)** anytime or log on to ***My*Health OnLine.**

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

UPMC AnywhereCare

AnywhereCare Virtual Urgent Care—UPMC Health Plan's telemedicine tool—offers Participants access to high-quality care from the comfort of their own home day or night. It works well for issues such as rashes, sore throats, colds, and other nonemergency issues.

Participants can have a virtual urgent care visit with a provider right from their smartphone, tablet, or computer.

The Participant can download UPMC AnywhereCare app from the App Store or Google Play™ by searching for "UPMC AnywhereCare," or the Participant can register at **anywherecare.upmc.com** from their computer.

Cultural, Linguistic, and Disability Competency

In-network Providers **must** demonstrate Cultural Competency, Linguistic Competency, and Disability Competency, Racial, ethnic, linguistic, gender, sexual orientation, gender identity, and cultural differences between Providers and Participants **must not** present barriers to Participants' access to and receipt of quality services. UPMC Community HealthChoices will monitor its in-network providers to ensure that Participants receive access free from such barriers, including ensuring access to traditional treatment methods and nontraditional treatment methods that are consistent with the Participant's racial, ethnic, linguistic, or cultural background and which **may** be equally or more effective and appropriate for the particular Participant. Providers **must** demonstrate consistency in providing quality care across a variety of races, ethnicities, and cultures.

All providers **must** comply with the Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 U.S.C. §§ 12101, *et seq*., Title VI of the Civil Rights Act of 1964, and all other legal and regulatory requirements outlined in Chapter B (Provider Standards and Procedures) of the UPMC Health Plan provider manual. UPMC Community HealthChoices providers **must** also comply with the following minimum requirements as appropriate to their setting and services:

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

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

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

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

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

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

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

- Providers **must** respond to disability complaints in a timely manner and keep records of such complaints.

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

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

In addition, UPMC Health Plan provides access to materials that can help facilitate a Recipient's request for interpretation services. Providers can order language interpretation signage that informs the Participant and their support person of interpretation services available.

The resources are available to UPMC providers through UPMC Infonet under options for patient-facing signage materials and on the UPMC Health Plan Provider Online at **upmchealthplan.com/providers** under the provider marketing materials section.

The provider can order "I Speak" cards for Participants requiring language assistance. The Participant can hand the card(s) to the office staff upon arrival to inform them of their preferred language. The "I Speak" cards can be ordered for print at **upmchealthplanc.com/HPOnLine/MarketingMaterials.aspx.**

Closer Look at Working with Interpreters

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

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

Closer Look at Alternative Format Documentation

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

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

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

Alzheimer's Disease and Other Dementias

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

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

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

Health Care Professionals – Resources and Information
From: The Alzheimer's Association

- Health Care Professionals Website**:**
  alz.org/professionals/healthcare-professionals

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

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

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

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

➢ **See: dhs.pa.gov/docs/For-Providers/Pages/Bulletin-Search.aspx**

Physical Health Services

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

Home and Community Based Services

If a Participant, upon enrolling in UPMC Community HealthChoices is receiving Home and Community Based services authorized by another CHC-MCO, those services will continue for **60 days or until a C**omprehensive Needs Assessment has been completed and a Person-Centered Service Plan (PCSP) has been developed and implemented, **whichever date is earlier.**

For Participants Who Are Pregnant

If a pregnant Participant is already receiving care from an out-of-network ob-gyn provider at the time of enrollment with UPMC Community HealthChoices, the Participant **may** choose to continue to receive an ongoing clinically appropriate course of treatment from that specialist throughout the pregnancy and postpartum care related to the delivery. Before authorization from the previous PH-MCO, CHC-MCO, or fee-for-service program expires, the provider needs to review prior authorization and referral requirements for the service(s) and make the necessary prior authorization request.

➢ **See:** ***Services Requiring Prior Authorization*****,** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

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

Services Not Covered

The following services **are not covered** by UPMC Community HealthChoices **unless** requested as a Program Exception and prior authorization is obtained from the Utilization Management Department. In-network providers **must** contact Utilization Management by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers** to determine if a service is eligible to be considered for a prior authorization. Out-of-network providers **must** contact **Utilization Management** at **1-800-425-7800.**

- Acupuncture
- Experimental or investigative treatments
- Home and vehicle modifications, other than approved Home Accessibility DME

  ➢ **Note:** UPMC Community HealthChoices Participants with LTSS **may** be eligible for home adaptations and vehicle modifications as part of their Person-Centered Service Plan subject to limitations found within the §1915(c) Home- and Community-Based Services Waiver.

  ➢ **See:** ***Covered Services*** for more information or call **Provider Services** at **1-844-860-9303** from 8 a.m. to 5 p.m. Monday through Friday.

  ➢ **See:** UPMC Health Plan's policy regarding ***Home Accessibility DME,*** located at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx#H)**

- Infertility services
- Medical services or surgical procedures and diagnostic tests performed on an inpatient basis that could have been performed in the provider's office, the clinic, the emergency department, or a short procedure unit without endangering the life or health of the Participant
- Nonmedically necessary treatments or surgery (e.g., cosmetic surgery)
- Out-of-country care (services provided outside of the United States)

  ➢ **See:** ***Out-of-Area or Out-of-Network Care*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

- Out-of-network care, except for emergency services and family planning
- Self-directed care, except as noted in the Coordinated Care section

  ➢ **See:** ***Coordinated Care*****,** UPMC Health Plan Provider Manual**,** Chapter N, UPMC Community HealthChoices (Medical Assistance).

Program Exception Process

UPMC Community HealthChoices has a Program Exception process, whereby a Provider or Participant **may** request coverage, under extraordinary circumstances, for items or services that are of a type covered by the Medical Assistance program but are **not** currently listed on the Medical Assistance Program Fee Schedule. A Program Exception will be approved only in extraordinary circumstances, and only if:

- The type of service is covered by the Medical Assistance program and is generally accepted by the medical community.
- The procedure is not experimental.
- The therapeutic effectiveness of the service has been scientifically documented.

The Program Exception process also applies to requests for additional treatment that exceeds a benefit limit (i.e., duration or quantity) of a particular service (a "Benefit Limit Exception request"). An exception to service limits **may** be granted if **one of the following** criteria is met:

- The Participant has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Participant or result in the rapid, serious deterioration of the health of the Participant.
- Granting a specific exception is a cost-effective alternative (i.e., the Participant would need a costlier service if the exception is not granted).
- Granting an exception is necessary to comply with federal law.

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

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

UPMC Health Plan
Utilization Management
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

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

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

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

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

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

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

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

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

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

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

The turnaround times for Program Exception requests are different from the turnaround times for Prior Authorization requests. Prior authorization requests use the following turnaround times:

Urgent pre-service requests are reviewed for medical necessity and a determination will be made **within 48 hours.** Providers will receive verbal notification of the decision **within 24 hours** of receipt of the request in addition to a written notification. The written notification is sent to the provider **within 48 hours** and a copy is sent to the Participant.

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

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

Closer Look at Dental Benefit Limit Exceptions

Dental Benefit Limit Exception:

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

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

➢ **Note:** If the dental BLE request identifies that the Participant has **one** of the conditions set forth below, as part of the dental BLE review process, UPMC Community HealthChoices will review the Participant's claim history to determine if the condition was previously identified on a claim:

- Diabetes
- Coronary artery disease or risk factors for the disease
- Cancer of the face, neck, and throat (**Does not** include **stage 0 or stage 1** noninvasive basal or sarcoma cell cancers of the skin.)
- Intellectual disability
- Current pregnancy, including postpartum period **(12 months)**

If the condition was previously identified on a claim, UPMC Community HealthChoices **will not** require supporting medical record documentation of the condition. If the condition was not previously identified on a claim, UPMC Community HealthChoices will notify the dental provider that supporting medical record documentation is needed to review the BLE request.

The supporting medical record documentation if the condition **was not** previously identified on a claim, and any additional information requested, **must** be submitted to Utilization Management **within 15 days** of UPMC Community HealthChoices request to the dental provider. Upon receipt of the medical record documentation or additional information, Utilization Management will review the request for a dental BLE to confirm that one of the criteria for the granting of a BLE is met. The dental provider and Participant will be informed of the Utilization Management determination by written Notice of Decision. If the BLE request is approved, the services can be provided and paid for as long as the Participant maintains UPMC Community HealthChoices eligibility.

Service Coordination

Role of Service Coordinators

Service Coordinators are qualified individuals (nurses, social workers, or those with experience serving the Waiver program populations) who are the accountable point of contact for each Participant with long-term care needs, whether the Participant lives in the community or in a nursing facility.

The Service Coordinator's role includes the following activities:

- Provide information about available services, needs assessments and the Person-Centered Service Plan (PCSP) process.
- Assist Participants in gaining access to needed LTSS and health care services (including durable medical equipment, pharmacy, dental services, etc.) by helping to identify, locate, and coordinate such services.
- Inform Participants about service alternatives and delivery options, including choice of service providers as well as opportunities for self-direction.
- Conduct person-centered Comprehensive Needs Assessments and develop PCSPs and Care Plans.
- Oversee the implementation of PCSPs.
- Assist with arranging and scheduling transportation to covered medical services through the Medical Assistance Transportation Program (MATP) as well as nonmedical transportation to appointments, activities, and resources as identified on the PCSP.
- Promote wellness and encourage the utilization of preventive care services.
- Provide education to caregivers based on the Participant's condition, including symptoms and/or triggers of changing health and functional status and appropriate actions to take.
- Prompt Participants to complete the redetermination process to maintain Medical Assistance eligibility, and assist with coordination as necessary.
- Assist Participants with the Complaint and Grievances processes and provide information about Participants' rights including DHS Fair Hearing rights.
- Coordinate supports outside of UPMC Community HealthChoices to address social determinants of health, behavioral health, and physical health needs including those provided through Medicare, BH-MCOs or other health insurers, and other community resources.

For more information or to speak with a Service Coordinator, contact the **Service Coordination Department** at **1-833-280-8508 (TTY 711).** Representatives are available from 8 a.m. to 5 p.m., Monday through Friday.

Role of the Provider for Participants who Receive LTSS

Providers have an integral role in the goal of seamless and continuous, Participant-centric care. To help achieve that goal, both medical and nonmedical providers **should**:

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

➢ **Note:** With approval from the Participant, UPMC Health Plan will provide the PCP, other health care provider(s) and home- and community-based service provider(s) that support the Participant's life in the community access to most of the Participant's person-centered service care plan details. The care plan can be found through **Provider OnLine** at **upmchealthplan.com/providers.** It is the responsibility of the provider to access this information as needed **(and only as needed)** to enhance the coordination or quality of care.

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

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

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

In addition, providers **must report** any suspected abuse, neglect, exploitation, or suspicious death through the appropriate channels, which may include protective services and law enforcement.

➢ **See:** ***Critical Incident Reporting***, UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices (Medical Assistance).

Every Participant has the right to choose or change their provider for medical and nonmedical services. Committed coordination and involvement in the Participant's PCPT **may** decrease such changes and lead to more consistent care and services.

Person-Centered Planning Teams

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

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

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

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

Comprehensive Needs Assessment and Reassessment

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

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

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

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

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

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

In the event of a hospital discharge, the Service Coordinator attempts to contact and conduct a reassessment **within two business days** of notification of discharge.

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

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

Person-Centered Service Plans (PCSP)

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

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

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

The PCSP comprises two key components:

- The Care Plan
- The Service Plan

Care Plan:

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

The Care Plan includes:

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

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

The Service Plan includes:

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

Participant Complaint, Grievance, and Fair Hearing Procedures

UPMC Community HealthChoices Participants have a Complaint, Grievance, and Fair Hearing process available to them if they are unhappy with services provided by UPMC Community HealthChoices or their provider. In order for the provider to represent the Participant in the conduct of a Grievance, the provider **must** obtain the written consent of the Participant and submit the written consent with the Grievance. A provider **may** obtain the Participant's written permission at the time of treatment. A provider **cannot** require a Participant to sign a document authorizing the provider to file a Grievance as a condition of treatment.

The written consent must include all of the following:

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

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

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

- **Note:** The UPMC Community HealthChoices Participant Complaint, Grievance, and Fair Hearing process is separate and distinct from the Provider Dispute process.

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

Provider Critical Incident Reporting Requirements

Reporting Requirements

UPMC Community HealthChoices requires **all in-network providers** to **report all Critical Incidents** involving UPMC Community HealthChoices Participants to the Participant's Service Coordinator **within 24 hours** of discovery, and after ensuring the health and safety of the Participant. Direct service providers **must also** report the incidents in the state's **Enterprise Incident Management (EIM) system within 48 hours**. All investigations and follow up activities **must be** completed and documented in EIM **within 30 days.** All information entered in the EIM system **must** be written in English.

Service providers and their subcontractors **may** submit a typed critical incident form.

The form **must** be submitted **within 24 hours from the date of discovery** and UPMC Community HealthChoices will submit the incident in the state's EIM system.

Any type of provider **may** use the online form as an alternative reporting method if the EIM system is not working.

The form is located on UPMC Health Plan website at **upmchealthplan.com/providers/hcbs/resources** and submitted to **chc_critical@upmc.edu.**

Requesting EIM access

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

Training

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

Critical Incidents Categories

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

- **Abuse,** which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a Participant. Types of abuse include, but are not limited to:
  - Physical abuse, defined as a physical act by an individual that **may** cause physical injury to a Participant.
  - Psychological abuse, defined as an act, other than verbal, that **may** inflict emotional harm, invoke fear, or humiliate, intimidate, degrade, or demean a Participant.
  - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a Participant.
  - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a Participant.

- **Any Preventable Serious Adverse Events (PSAEs)** discovered in a nursing facility **must** be reported in compliance with the **Office of Long-Term Living bulletin #03-14-08 issued 09/13/2014 and effective 10-01-2014.** The facility **must** also notify UPMC Community HealthChoices on the claim and email it to **chc_critical@upmc.edu.**

- **Death** (if suspicious in nature or unexpected only)

- **Emergency room visits**
  For the purposes of Critical Incident reporting, an emergency room visit is defined as the use of a hospital emergency room. This includes situations that are clearly emergencies, such as a serious injury, life-threatening medical conditions, medication errors, as well as those when an individual is directed to an emergency room in lieu of a visit to the PCP or as the result of a visit to the PCP. The use of an emergency room by an individual, in place of the physician's office, is not reportable.

- **Exploitation,** which is an act of depriving, defrauding, or otherwise obtaining the personal property from a Participant in an unjust or cruel manner against one's will or without one's consent or knowledge for the benefit of self or others.

- **Medication errors** that result in hospitalization, an emergency room visit, or other medical intervention.

- **Neglect,** which includes failure to provide a Participant the reasonable care they require, including, **but not limited** to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Neglect includes:
  - Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect.
  - Abandonment, which is the desertion by anyone who assumed caregiving responsibilities for a Community HealthChoices Participant.

- **Provider or staff misconduct**, including deliberate, willful, unlawful, or dishonest activities

- **Restraint**, which includes any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations, or activities, or restricts Participant rights.

- **Serious injury** that results in emergency room visits, hospitalizations, or death

- **Service interruption,** which includes any event that results in the Participant's inability to receive services that places their health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the Participant's backup plan. If these events occur, the provider agency **must** have a plan for temporary stabilization.

- **Unplanned hospitalization**

Immediate First Steps for Suspected Abuse, Neglect, Exploitation Incidents

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

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

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

   ➢ **Note:** Liberty Healthcare **should only be contacted for emergency situations** requiring immediate attention.

3. Submit a written **Act 70 Mandatory Abuse form** after any verbal report taken by OAPS or APS worker. The Act 70 Mandatory Abuse Report Form **must** be sent to APS or OAPS (depending on participant age).

    - **For ages 18-59:**
        - Fax to **484-434-1590,** or
        - Email the report to **Liberty Healthcare** at **mandatoryron@libertyhealth.com.**
    - **For ages 60+:**
        - Fax reports to **PDA** at **717-772-2668.**
    - If the incident involves sexual abuse, serious bodily injury, serious injury, or suspicious death, call local law enforcement and provide a copy of the Act 70.
    - The Act 70 form is available online at:
        - UPMC Community HealthChoices Provider Resources website at **upmchealthplan.com/providers/hcbs/resources/**
          or
        - **dhs.pa.gov/about/Fraud-And-Abuse/Documents/Act%2070%20Form.pdf**
    - Instructions for completing the Act 70 form are available online at **dhs.pa.gov/about/Fraud-And-Abuse/Documents/70%20form%20instructions.pdf**
    - More information about the Mandatory reporting requirements is available in the DHS memorandum: **dhs.pa.gov/about/Fraud-And-Abuse/Documents/mandatory%20guidance.pdf**

4. **Within 24 hours, from the time of discovery,** call the **UPMC Community HealthChoices Service Coordination Department** at **1-833-280-8508 (TTY: 711)** to make a verbal report. Representatives are available from 8 a.m. to 5 p.m. Monday through Friday. If there is no answer, then contact the **UPMC Community HealthChoices Health Care Concierge team** at **1-844-833-0523** to make a verbal report**. At a minimum,** the verbal report **must include** the following information:
    - Participant's full name
    - Date of birth
    - Date and time of incident
    - A brief description of the incident
    - The Participant's current condition
    - Actions taken to mitigate risk to the Participant
    - The reporter's name, agency, and contact information

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

> ➢ **Note:** If a provider encounters a situation when serving a Participant that requires access to emergency services for their safety and protection, the provider **should** contact local law enforcement and protective services as needed, then notify the **UPMC Service Coordination Department** at **1-833-280-8508 (TTY:711).** UPMC Health Plan will route the information to the designated unit to respond with additional provider support.

Possible Actions Needed After an Incident

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

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

Follow-Up Responsibilities

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

> ➢ **See:** ***Office of Long-Term Living bulletin number*** #5-23-02, 51-23-02, 54-23-02, 55-23-02; 59-23-02, 03-14-08, effective February 23, 2023, for additional information.

Nursing Facility Quality of Care Reviews and Preventable Serious Adverse Event Reporting

Nursing Facility Quality of Care (QOC) Reviews

QOC Reporting and Referrals

If an employee at a nursing facility, the Participant, the Department of Health (DOH), or a mandatory reporter such as UPMC employees, UPMC Network providers, or subcontractors identifies a possible Quality of Care (QOC) concern or Preventable Serious Adverse Event (PSAE) involving a UPMC Community HealthChoices Participant, then they **must** report the event to DOH and UPMC Health Plan. If the QOC event involves allegations of abuse, neglect, exploitation, or suspicious death, then the event **must** be reported to Adult Protective Services/Older Adult Protective Services.

➢ **See:** Provider Critical Incident Reporting Requirements, for information about ***Adult Protective Services/Older Adult Protective Services Reporting,*** UPMC Health Plan Provider Manual, Chapter N, Community HealthChoices (Medical Assistance).

QOC Investigation

For QOC referrals, UPMC Health Plan will review records, investigate actions taken and witness statements received to determine if proper corrective action was taken to mitigate the risk to the Participant and prevent future incidents of a similar nature. UPMC Health Plan will contact the nursing facility to request the Participant's medical records, any applicable facility policies or processes relating to the event, and any corrective actions taken by the facility to mitigate the risk and prevent future QOC issues in the future. Complying with records requests is **required** by the facility in their contract. The timeline for return of these records is **within 10 business days** of request receipt.

Nursing Facility Quality of Care Examples	
Abuse/Neglect	Improper infection control procedures
Burn – 2nd degree or higher	Improper wound care
Care plan not followed	Medication error
Choking/Aspiration resulting in death	Nutritional issue
Elopement	Rights violation
Failure to follow physician's order	Serious injury
Failure to meet professional standards for care	Failure to train staff properly on care plan
Fall with serious injury	Suspicious death
Fall without serious injury	Stage 2, 3, 4, or unstageable pressure injury
Failure to provide a participant environment free of accidental hazards	

Confirmation of QOC Severity Level

The QOC referral and collateral information is reviewed by clinical staff in the UPMC Health Plan Quality Improvement Department. The QOC event will be assigned a severity level.

QOC Severity Levels

- **Level 0** – No confirmed quality of care problem
- **Level 1** – Potential quality problem without significant adverse effect on the Participant
- **Level 2** – Potential quality problem with the potential for significant adverse effect on the Participant
- **Level 3** – Potential quality problem with significant adverse effect on the Participant

UPMC Health Plan **may** request additional information to better understand a facility's Quality Assurance Process Improvement (QAPI) process, review specific facility procedures, and make additional recommendations for further education or corrective action. When UPMC Health Plan identifies an ongoing concern with a facility or that the corrective action taken was not deemed sufficient to rectify the QOC concern, UPMC Health Plan **may:**

- Request additional information, if it is determined that the response to the DOH did not adequately address all QOC concerns identified.
- Request policies or copies of audits conducted on corrective action steps in the DOH report.
- Recommend courses on the Jewish Healthcare Foundation's Nursing Facility Learning Collaborative Network. This website offers education for Pennsylvania nursing facilities on multiple topics including infection control, fall risk, Root Cause Analysis, and pressure injuries.

Preventable Serious Adverse Event (PSAE) Reporting and Processing

Confirmed QOC cases are also evaluated to see if they meet the criteria of a PSAE. PSAEs **must** meet all **four** conditions listed in the PSAE Criteria section below. Once confirmed, a PSAE case is forwarded to the UPMC Fraud, Waste, and Abuse (FWA) department for recovery of funds paid to the nursing facility for the days the participant was affected by the PSAE. Any self-identified PSAEs by nursing facilities must be reported in compliance with the **Office of Long-Term Living Bulletin #03-14-08 issued 09/13/2014 and effective 10/01/2014.** The facility **must** also notify UPMC Community HealthChoices on the claim and email it to **CHC_Critical@UPMC.edu.**

PSAE Criteria

- Events that could have been prepared for or anticipated *(preventable)*
- Event subsequently ends in death or loss of body part, disfigurement, disability, or loss of bodily function lasting **more than seven days** or still present at the time of discharge from a Nursing Facility *(serious)*
- Event was in the control of the Nursing Facility
- Event is the result of an error or other system failure within the Nursing Facility

Medical Assistance Provider Compliance Hotline

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

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

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

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

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

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

Provider Monitoring

UPMC Community HealthChoices – Provider Monitoring Program

UPMC Community HealthChoices monitors Home and Community Based Service (HCBS) providers **at least once every two years.**

The roles and responsibilities of the UPMC Community HealthChoices Provider Assistance and Oversight Team (PAOT) are to:

- Verify the provider's compliance with **55 Pa Code Chapters 52, 1101, and 1150,** the Community HealthChoices waiver, and the UPMC Community HealthChoices HCBS provider contract.
- Conduct regulatory monitoring, which includes reporting and requiring a Corrective Action Plan (CAP), as necessary.
- Determine best practices and provide feedback on process improvement opportunities.
- Assist providers with obtaining answers to questions and/or resolving issues.
- Identify potential areas of training.

Providers enrolled in the UPMC Community HealthChoices HCBS provider network and those who are actively providing services to and billing for a UPMC Health Plan Participant are eligible for monitoring.

- Providers are monitored at **one location** per the Master Provider Index (MPI) number.
- The UPMC Community HealthChoices PAOT will contact those providers with multiple office locations to identify the main location where the monitoring will take place.
- Providers unable to accommodate onsite monitoring will be assigned an alternate location.

Provider Expectations

Providers are expected to provide the UPMC Community HealthChoices PAOT with the following:

- A workspace for **up to three** people
- Access to the office from 9 a.m. to 4 p.m., with the understanding that times **may** vary depending on agency office hours
- Information on available parking

In addition, providers **must** have the ability to open and work in Microsoft Word, the program in which PAOT documents are stored.

It is expected that providers work professionally with the PAOT to ensure that all information needed during the monitoring process is received timely and in a manner that satisfies all requirements.

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

Monitoring Process

Providers are notified via email, **up to 14 calendar days,** prior to the monitoring date. UPMC Community HealthChoices provides this notice as a courtesy, but monitoring **may** occur announced or unannounced.

- The email is sent from **one** of UPMC Community HealthChoices' respective service accounts and includes the following items:
  - A monitoring notification letter
  - A request for employee names via an attached employee template
  - A confirmation of the location where the monitoring will occur
  - A request for the provider to send a confirmation email

A request to reschedule the monitoring is only considered in the case of an emergency or if there are extenuating circumstances. The rescheduling request is submitted in writing, via email, and **must** include a detailed justification. The request is reviewed by the respective monitoring manager who determines whether to reschedule the monitoring.

➢ **See: Table N8: *Provider Advisory & Oversight Team – Contact Information,*** UPMC Health Plan Provider Manual, Chapter N, Community HealthChoices (Medical Assistance).

During these onsite monitoring meetings, the POAT's review will include, **but not be limited** to, verification of required policies and procedures, and review of employee files (including background checks and licensure, when appropriate). Providers **must** have established qualifications (e.g., job descriptions) for each position, conduct background checks on all employees who provide direct care to Participants, and utilize an additional tool (e.g., an interview or reference checks) for each paid employee hired. Providers **must** share documentary evidence of these requirements for each employee with UPMC Health Plan upon request.

As part of the monitoring process, the UPMC Community HealthChoices PAOT will issue a Statement of Findings (SOF) to the provider identifying areas of noncompliance.

- If applicable, the SOF report is emailed to the provider **within 15 business days** of the completion of the monitoring review.

- The provider is responsible for returning their Corrective Action Plan (CAP) **within 15 business days** as identified on the document.

- The CAP **must** include:
  - Action steps to correct each finding(s).
  - Action steps to prevent future system reoccurrences.
  - Agency's responsible person(s) with their titles.
  - Date for complete remediation.
  - Agency's internal quality management.

- The PAOT will either approve the submitted CAP or return for corrections.

CAP follow-up reviews occur **approximately 60 calendar days** after the last remediation date, as indicated by the provider.

- The provider is notified **up to 10 business days** in advance of the CAP follow-up.
- The PAOT reviews each finding and ensures the documentation matches the action steps as stated on the approval CAP.
  - If all findings are determined to be complete, the CAP is closed.
  - If there are findings that are determined to be incomplete, the provider has **five business days** to submit documentation verifying the finding has been remediated.

Table N8: Provider Advisory and Oversight Team – Contact Information	
Southwest and West Central service account email	**chc_provider_help@upmc.edu**
Southeast service account email	**CHCProviderMon@upmc.edu**
East Central service account email	**CHCProviderMonhelp@upmc.edu**

Additional Provider Requirements

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

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

- Providers within UPMC Community HealthChoices' provider network **are prohibited** from soliciting individuals to receive services from the provider, including:
    - Referring an individual for Community HealthChoices evaluation with the expectation that, **should** Community HealthChoices enrollment occur, the provider will be selected by the Participant as the service provider;
    - Communicating with existing Community HealthChoices Participants via telephone, face-to-face, or written communication for the purpose of petitioning the Participant to change providers;
    - Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential Community HealthChoices Participants. Providers in the CHC-MCOs network are allowed to outreach to hospitals, discharge planners or other institutions only to provide education and information about their agency/program; they cannot solicit for any potential CHC Participants. The provider cannot solicit for referrals of CHC Participants, nor can they offer or provide any incentives to the hospital/Institutions, discharge planner, or any other staff member.

Electronic Visit Verification

UPMC Health Plan requires the use of Electronic Visit Verification (EVV) for all Medical Assistance funded in-home personal care services, respite care services, and home health care services as mandated by Section 12006(a) of the 21st Century Cures Act. As of Jan. 1, 2020, EVV **must** be used for all in-home personal care services and respite care services provided to UPMC Community HealthChoices participants by HCBS Providers. As of Jan.1, 2024, EVV **must** also be used for all home health care services provided to UPMC Community HealthChoices participants by home health and HCBS Providers.

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

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

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

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

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

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

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

Other Resources and Forms

Additional resources, forms, and policies can be found at **upmchealthplan.com/providers.** Some key forms and resources are listed below.

Telehealth and Clinical Practice Guidelines

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

Medical Prior Authorization

- Prior authorization information materials
- Patient health guidelines
- Physician forms

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

Pharmacy Prior Authorization

- Prior authorization forms

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

Copayment Schedule

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

Table N9: Copayments Schedule – Adult Medical Assistance Participants	
Services	**Copay**
Ambulance (per trip)	$0
Dental Care	$0
Diagnostic Services (Not performed in a doctor's office)	
Medical diagnostic testing (per service)	$0
Nuclear medicine (per service)	$0
Radiation therapy (per service)	$0
Radiology diagnostic testing (per service)	$0
Inpatient Hospital (Acute or Rehab)	
Per day	$0
Maximum with limits	$0
Medical Centers	
Ambulatory Surgical Center	$0
Convenience care or Urgent care centers	$0
Emergency Department (nonemergent visits)	$0
Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)	$0
Short procedure unit	$0
Medical Equipment	
Purchase or rental	$0
Medical Visits	
Certified nurse practitioner	$0
Chiropractor	$0
Doctor (PCP, ob-gyn)	$0
Optometrist	$0
Podiatrist	$0
Therapy (Occupational, Physical, Speech)	$0
Outpatient Hospital (Includes Hospital Based Clinics)	
Per visit	$0
Prescriptions	
Brand	**$3**
Generic	$0