Utilization Management and Medical Management

At a Glance

The Utilization Management Department or the Medical Management Department at UPMC Health Plan is responsible for managing health care resources. To this end, the department(s):

- Authorizes coverage of certain procedures.
- Performs predetermination reviews.
- Authorizes out-of-network and out-of-area care.
- Approves Member transfers to out-of-network facilities.
- Offers case management services for medically complex cases.
- Provides access to Enhanced Member Supports services.
- Provides access to health management services for Members with specific chronic diseases.
- Administers Member and provider surveys and assessments.

For questions and additional information, call:

• **Care Management** • **Case Management** • **Complex Case Management** • **Health Management** • **Maternity Program**	**1-866-778-6073 (TTY: 711)**	Monday through Friday from 7 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.
• **Enhanced Member Supports Unit (EMSU)**	**1-866-463-1462 (TTY: 711)**	Monday through Friday from 7 a.m. to 8 p.m. Saturday from 8 a.m. to 3 p.m.
• **Utilization Management**	**1-800-425-7800 (TTY: 711)**	Monday through Friday from 8 a.m. to 4:30 p.m.

Procedures Requiring Prior Authorization

Prior authorization—often referred to as pre-service decision, prospective review, precertification, or predetermination—is the process UPMC Health Plan uses to review specific procedures or treatments to determine whether the coverage of a request will be approved or denied. UPMC Health Plan will review a provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the provider's initiation or continuation of the requested service.

Medical policies outlining items, services, and procedures that require review for prior authorization are available online at **upmchealthplan.com/providers.** Hard copies are available upon request. Contact **Provider Services,** Monday through Friday from 8 a.m. to 5 p.m., at:

UPMC Community HealthChoices (Medical Assistance)	**1-844-860-9303**
UPMC *for Kids* (CHIP)	**1-800-650-8762**
UPMC *for Life* (Medicare)	**1-877-539-3080**
UPMC *for Life* Complete Care (HMO D-SNP)	**1-877-539-3080**
UPMC *for You* (Medical Assistance)	**1-866-918-1595**
UPMC Health Plan (Commercial)	**1-866-918-1595**
TTY	**711**

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

If a provider wants to ask for a prior authorization review, the request **must** be submitted through **Provider OnLine** at **upmchealthplan.com/providers** or a written request can be submitted to:

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

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

The provider **must** include the medical justification that will be considered in the approval or denial of the procedure. If coverage is denied, the provider **may** appeal the decision by following the appeal process that is included with the letter of denial.

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

Closer Look—Treatment Elected by the Member

If approval **is not** granted, but the Member elects to receive the treatment, the Member **must** sign a statement accepting financial responsibility for the costs of the care prior to receiving the service. This statement **must** be retained in the medical record.

➢ **Note:** This **is not** applicable for Medicare. The ***Integrated Denial Notice (IDN)*** process should be followed in order to bill a Medicare Member for denied services.

➢ **See: UPMC Health Plan Provider Manual**

- ***Integrated Denial Notice*****,** Chapter B, Provider Standards and Procedures.
- ***Covered Benefits and Services for HMO and PPO Members*****,** Chapter F, UPMC *for Life*.
- ***Covered Benefits and Services*****,** Chapter M, UPMC *for Life* Complete Care (HMO D-SNP).

How to Contact or Notify Utilization Management

Providers may contact the Utilization Management Department when they have questions or need additional information by calling **1-800-425-7800 (TTY: 711),** from 8 a.m. to 4:30 p.m., Monday through Friday.

Providers **may** submit a request for prior authorization, including supporting documentation and the Certificate of Medical Necessity (CMN), using the following methods:

- Electronically through **Provider OnLine** at **upmchealthplan.com/providers**
- Sending a written request to:

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

When to Notify Utilization Management

UPMC Health Plan (Commercial)

Providers **must** contact the Utilization Management Department to authorize coverage for:

- Out-of-area and/or out-of-network care for a Member, including the transfer of a Member from one hospital to another.
- Coverage for certain specific procedures.
- Some home medical equipment (HME), including specialty wheelchairs and scooters, which are known as power mobility devices (PMDs).
- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, long-term acute care centers, acute impatient mental health facilities, chemical dependency rehabilitation facilities, and chemical dependency detoxification facilities This enables UPMC Health Plan to identify Members' special needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.
- Any service, item, or procedure that requires a prior authorization.

➢ **See: UPMC Health Plan Provider Manual**
- Chapter C, UPMC Health Plan Commercial.
- Chapter L, UPMC Health Plan Behavioral Health Services.

UPMC Community HealthChoices and UPMC *for You* (Medical Assistance)

Providers **must** contact the Utilization Management Department to authorize coverage for:

- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, and long-term acute care centers. This enables UPMC Health Plan to identify UPMC Community HealthChoices Participants and UPMC *for You* Members' enhanced healthcare and/or health related social needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.
- Certain outpatient services including pain management services; home health services, enteral/parenteral feedings, and nutritional supplements; and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) expanded services.
- Skilled nursing facility care.

- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs).
- Out-of-network services.
- Benefit Limit Exception (BLE) requests.
- Any service, item or procedure that requires a prior authorization.

➢ **Note:** This **is not** a complete listing of services that require a prior authorization.

➢ **See: UPMC Health Plan Provider Manual**
- Chapter E, UPMC *for You*, (Medical Assistance).
- Chapter N, UPMC Community HealthChoices (Medical Assistance).

UPMC *for Life* (Medicare)

Providers **must** contact the Utilization Management Department to authorize coverage for:

- Out-of-area and/or out-of-network care for a Member, including the transfer of a Member from one hospital to another.
- Coverage for certain specific procedures.
- Some home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs).
- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, long-term acute care centers, acute inpatient mental health facilities, chemical dependency rehabilitation facilities, and chemical dependency detoxification facilities. This notification is essential to ensure appropriate reimbursement and to meet UPMC Health Plan's reporting requirements to the Centers for Medicare & Medicaid Services (CMS).
- Any service, item, or procedure that requires a prior authorization.

➢ **See: UPMC Health Plan Provider Manual**
- Chapter F, UPMC *for Life* (Medicare).
- Chapter L, UPMC Health Plan Behavioral Health Services.

UPMC *for Kids* (CHIP)

Providers **must** contact the Utilization Management department to authorize coverage for:

- Out-of-network services.
- **Some** home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs).
- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, long-term acute care centers, acute inpatient mental health facilities, chemical dependency rehabilitation facilities, and chemical dependency detoxification facilities. This enables UPMC *for Kids* to identify Members' enhanced healthcare and/or health related social needs and coordinate their care. In some cases, clinical staff may help arrange care in an alternate setting.
- Certain outpatient services, including private duty nursing, enteral/parenteral feedings, and nutritional supplements.
- Any service, item, or procedure that requires a prior authorization.

> ➢ **See: UPMC Health Plan Provider Manual**
>
> - Chapter D, UPMC *for Kids* (CHIP).
> - Chapter L, UPMC Health Plan Behavioral Health Services.

UPMC *for Life* Complete Care (HMO D-SNP)

Providers **must** contact the Utilization Management Department to authorize coverage for:

- Out-of-area and/or out-of-network care for a Member, including the transfer of a Member from one hospital to another.
- Coverage for certain specific procedures.
- **Some** home medical equipment (HME), including the purchase of specialty wheelchairs and scooters known as power mobility devices (PMDs).
- Any inpatient admissions to acute care hospitals, skilled nursing facilities, rehabilitation facilities, long-term acute care centers, acute inpatient mental health facilities, chemical dependency rehabilitation facilities, and chemical dependency detoxification facilities.
- Any service, item, or procedure that requires a prior authorization.

This notification is essential to ensure appropriate reimbursement and to meet UPMC Health Plan's reporting requirements to the CMS.

> ➢ **See: UPMC Health Plan Provider Manual**
>
> - Chapter M, UPMC *for Life* Complete Care (HMO D-SNP).
> - Chapter L, UPMC Health Plan Behavioral Health Services.

Closer Look at UPMC *for Life* Complete Care (HMO D-SNP)

This Medicare Special Needs Plan provides medical and prescription drug benefits for beneficiaries eligible for both Medicare Parts A and B, and full Medical Assistance. UPMC *for Life* Complete Care (HMO D-SNP) offers enhanced dental and vision benefits for dual eligible beneficiaries, along with extra benefits and services that help Members manage their overall health and wellness. UPMC *for Life* Complete Care can also help coordinate a Member's Medicare and Medical Assistance services.

All Members

Providers are encouraged to call Medical Management to:

- Access enhanced healthcare services.
- Seek case management services for Members with multiple or complex needs who require the skills and care of a variety of providers.
- Access special disease management or lifestyle programs and services.
- Have a peer-to-peer discussion about prior authorization request denials.

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

- ***Case Management Services***
- ***Health Management Programs***
- ***Peer-to-Peer Discussion***
- ***Special Needs Services***

Alert—Emergency Care

Emergency services **do not** require prior authorization. Providers **must** notify **Utilization Management** at **1-800-425-7800 (TTY: 711)** whenever they have directed a Member to seek out-of-network emergency care. If the Member is admitted to an out-of-network hospital for an emergency medical condition, the provider **must** contact **Utilization Management** at **1-800-425-7800 (TTY: 711)** and ask to speak to a medical review nurse. The nurse may coordinate a transfer to a hospital appropriate to the Member's benefit plan when the Member is medically stable.

➢ **See:** ***45 CFR 149.410(b) of the No Surprises Act*** for additional information on Post Stabilization hospital transfers at **ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149.**

Alert— Closely Related Services

If a provider has been authorized by UPMC Health Plan to perform a service, it **may** be the case that in performing that service, minor differences in observed patient characteristics, or the need for diagnostic information that **was not** readily identifiable prior to performing the services, **may** require the provider to perform a closely related service in conjunction with, or in lieu of, the originally authorized service (a "Closely-Related Service").

If a provider performs a Closely-Related Service that was **not** included with the initial authorization, UPMC Health Plan **must** be notified **within three business days** of the procedure, and include all relevant clinical information supporting the medical necessity and appropriateness of the Closely-Related Service. If UPMC Health Plan is **not** provided this notice and information, the claim for the Closely-Related Service **may** be denied.

Peer-to-Peer Discussions:

Providers **may** request a peer-to-peer discussion with a UPMC Medical Director via telephone regarding prior authorization request denials during normal business hours and outside of normal business hours subject to reasonable limitations of availability. Providers **should** contact **Clinical Operations/Utilization** at **412-454-2765,** Monday through Friday from 8 a.m. to 5 p.m.

- **UPMC Community HealthChoices, UPMC *for Kids*, UPMC *for You,* UPMC Health Plan (Commercial):**
  Prior authorization request denials are available for discussion from the time of denial until the internal grievance process or internal adverse benefit determination appeal process commences.

- **UPMC *for Life,* UPMC *for Life* Complete Care (HMO D-SNP):**
  For Medicare plans, peer-to-peer reviews **cannot** be used to overturn cases. When the prior authorization case is denied, the provider will need to submit an appeal with the Complaints and Grievances Department. An appeal can be filed **within 65 calendar days** of the denial.

➢ **See:** ***Provider Disputes, Initiating an appeal on behalf of the Member,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

Case Management Services

Case management is available to all UPMC Health Plan Members who need assistance with coordinating health care services or accessing resources. Registered nurses and social workers, referred to as health coaches, assist Members with needs spanning various aspects of social services and the medical community. There are **two** levels of case management services: complex and general.

- **Complex case management** is the coordination of care and services for Members who have experienced a critical event or diagnosis that requires extensive use of resources. Members who have a clinically advanced illness and multiple comorbid disease states and need help navigating the system to facilitate appropriate delivery of care and services are eligible for complex case management.

- **General case management** applies to Members involved in care management who need short-term support, basic education, or linked to resources.

Closer Look at Diseases and Situations

Certain diseases and situations prompt a health coach to telephone a Member, seeking permission to be involved in the Member's care. Situations that **may** prompt Case Management services **may not** be limited to those mentioned above. If a provider believes a Member would benefit from case management, the provider should call **1-866-778-6073 (TTY: 711).**

Complex Case Management

At UPMC Health Plan, complex case management coordinates services for Members with complex conditions and helps them access needed resources. Many times, complex case management Members have a clinically advanced illness and multiple comorbid disease states and they need help navigating the medical care delivery system to receive appropriate care and services. At the same time, Members needing complex case management **may have** experienced a critical event or diagnosis that requires extensive use of resources and assistance for a brief period.

Eligibility requirements

Members with complex needs are identified through a variety of sources, including:

- Claims or encounter data related to use of services, types of providers seen, and cost of care.
- Pharmacy data.
- Hospital discharge data or information collected through Utilization Management processes, including precertification requests, concurrent reviews, prior authorization reviews, and reviews of hospital admission and readmission data.

Members can also be referred to complex case management through:

- Practitioners.
- The **24-hour** nurse advice line (health information line).
- The staff managing the Member as part of disease or health management programs.
- A discharge planner.
- Utilization Management staff.
- Member, family, or another caregiver; self-referral.
- Ancillary providers, behavioral health providers or behavioral health managed care organizations, pharmacists, the Medication Therapy Management Program, disability management programs, other internal departments, employer groups, or staff from community agencies.

> ➢ **Note:** Enrollment in the Complex Case Management Program **is voluntary,** and Members **may** decide to disenroll at any time.

In addition to referrals from multiple internal and external sources, a **monthly** report is created based on claims data to identify Members who may benefit from the Complex Case Management Program. These Members may have experienced a critical event or received a diagnosis that requires the extensive use of resources. Most of the Members who are identified need help navigating the health care system. These Members can benefit from health coaches helping to educate them on their condition(s), addressing barriers, and linking them to needed services or community agencies.

Available Services

The program puts the Member in touch with a health coach who will work with the Member and their medical team. The health coach determines how to best assist the Member after assessing the Member's situation, intensity of needs for health care services, level of services needed, care coordination, education, and support. Coordination of the case management plan with the treating practitioner will occur where appropriate.

Specific assistance offered:

- An evaluation of the Member's cultural and linguistic needs, preferences, or limitations
- An evaluation of the Member's caregiver resources that are in place to support them with appropriate care and decision making
- An evaluation of available benefits and associated financial burdens, as well as what may be needed to support the Member's treatment plan and identified needs
- Development of a case management plan that:
    - Addresses the identified needs
    - Includes long- and short-term goals
    - Establishes a time frame for re-evaluation
    - Identifies resources to be used and at what level of care
    - Provides a continuity of care plan and determines the assistance that is needed; and uses a collaborative approach that identifies who will be included, such as family practitioner, pharmacist, or community-based services
- Identification of barriers to the Member's meeting goals or complying with the plan, which includes such factors as poor compliance to the treatment plan, lack of understanding, not ready to make a change, financial hardships, poor supports, transportation issues, or fragmented care
- Helping the Member develop a self-management plan that may include how they will monitor the disease, use a practitioner-provided symptom response plan, comply with prescribed medications, and attend practitioner visits
- Following the Member's progress against the case management plan that was developed for the Member, including progress toward overcoming identified barriers, any adjustments to the care plan, and following the self-management plan
- Coordination of care for multiple services, including inpatient, outpatient, and ancillary services
- Facilitating access to care
- Establishing a safe and adequate support system through interactions with the Member and/or applicable caregivers

Referring a Member to the Complex Case Management Program

Providers may refer a Member for the **Complex Case Management Program** or ask questions about the program by calling **1-866-778-6073 (TTY: 711).** Representatives are available Monday through Friday from 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m.

Enhanced Member Supports Services

UPMC Health Plan offers enhanced member healthcare and/or health related social needs support services for UPMC *for You* (Medical Assistance) Members who may have complex physical health needs, multiple physical or behavioral health needs, or special communication needs. Members may be handicapped or disabled and require community services, or they may just need extra guidance in obtaining health care services.

Care Managers will identify Members who may benefit from care coordination. **Care Management staff** is available at **1-866-778-6073 (TTY: 711),** Monday through Friday from 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m.

➢ **See:** ***Enhanced Member Supports Unit (EMSU)*** UPMC Health Plan Provider Manual**,** Chapter E, UPMC *for You* (Medical Assistance).

Special Needs triggers include, but are not limited to, the following:

- Asthma
- Birth defect
- Cancer
- Developmental disability
- Diabetes
- Drug/alcohol problems
- Hearing impairment
- Heart disease
- High blood pressure
- HIV/AIDS
- Intellectual Disability
- Kidney problems
- Maternity
- Mental health conditions
- Physical disability
- Sickle cell disease
- Speech impairment
- Substitute care
- Transportation
- Visual impairment
- Wheelchair accessibility

Closer Look at Enhanced Member Supports Services for UPMC *for You* Members

The Enhanced Member Supports Unit (EMSU) is staffed by nurses, social workers, and other professionals who are available Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Any provider or Member may contact the EMSU at **1-866-463-1462 (TTY: 711)** for assistance in obtaining community services or other coordination of care services.

Enhanced Member Supports Services can:

- Coordinate health care services with providers and agencies.
- Identify Members who could benefit from case management and UPMC Health Plan health management programs.
- Identify community agencies and services that may meet the needs of a Member.
- Function as the identified liaison with county children and youth agencies and juvenile probation offices.
- Assist in coordinating routine transportation.
- Educate Members about how to access health care services within their benefit package.
- Assist Members who have reached benefit limits.
- Assist Members who are seeking treatment or services that are consistent with the Members' cultural background.
- Assist Members who have difficulty communicating with making appointments.
- Assist providers in locating language interpreters and those who can provide American Sign Language or other forms of visional/gestural communication.
- Identify providers who speak languages other than English.

Health Management Programs

Health management programs are an important component of UPMC Health Plan's efforts to improve Members' health by providing intensive case management for Members with specific chronic illnesses. UPMC Health Plan offers a maternity program and programs for Members with diabetes; asthma; COPD; chronic heart disease, including heart failure, coronary artery disease, hypertension, and hyperlipidemia; depression; ADHD; and high-risk behavioral health issues.

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

All interventions are aimed at increasing Members' knowledge of their condition and improving their ability to manage their disease. A specialized team of health coaches (nurse care managers and social workers), in collaboration with the Members' providers, works to accomplish these goals through Member education, coordination of care, and timely treatment.

In addition, these programs provide help for Members 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.

UPMC Health Plan also has programs to assist with lifestyle goals such as smoking cessation, weight management, nutrition, stress management, and physical exercise. Members enrolled in these programs receive educational materials and **may** be eligible for classes.

Providers who serve Members who would benefit from these health management programs should contact **Health Management** at **1-866-778-6073 (TTY: 711)** for information and enrollment. Health Management staff is available Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. Additional information on health management programs can be found in the Providers section of the UPMC Health Plan website at **upmchealthplan.com/providers.** If a Member enrolls in a health management program, their provider will be notified.

Maternity Programs

UPMC Health Plan offers Baby Steps, a maternity care management program for all pregnant Members. Health coaches provide education, coordination of care and referrals to a variety of resources to address identified Member needs. Interactions are available by telephone or virtual/telehealth encounters. Face-to-face interactions by mobile maternity health coaches are available in certain geographic regions. The focus of the program is to help Members achieve and maintain a healthy pregnancy and safe delivery.

For more information about the **UPMC Health Plan Baby Steps Maternity Program** call **1-866-778-6073 (TTY: 711).** Health Management staff is available Monday through Friday from 7 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m., or send a fax to **412-454-8558.** For more information about any of the Health Management programs, contact **Health Management** at **1-866-778-6073 (TTY: 711).**

Closer Look at Virtual/Telehealth Visits

UPMC AnywhereCare Virtual Care—UPMC Health Plan's telemedicine tool—offers Members access to high-quality care from the comfort of their home **24 hours a day, 7 days a week, 365 days a year.** It works well for issues such as rashes, sore throats, colds, and other nonemergency condition. Members can have a virtual care visit with a provider right from their smartphone, tablet, or computer. The Member downloads the UPMC Health Plan app. They can also access it online by visiting **upmchealthplan.com** to register and then select UPMC Anywherecare in the Care section to access their needed care option.

UPMC AnywhereCare offers care to Members of all ages. With UPMC Children's AnywhereCare, children **ages 0-17** can have a virtual care visit **24/7** with UPMC Children's Hospital of Pittsburgh providers. In order for a child (**ages 0-17**) to have a UPMC Children's AnywhereCare visit, the child's parent or legal guardian **must** be with the child during the video portion of the visit.

- **Note:** UPMC *for You* Members who are in Pennsylvania at the time of a virtual visit **may** select a UPMC-employed provider, subject to availability and discretion of the provider. Members temporarily traveling outside of Pennsylvania at the time of service will receive care from a provider employed or contracted by Online Care Network II PC (OCN), also known as Amwell Medical Group. Providers are **not** available to treat Members who are in Puerto Rico. Talk therapy and psychiatry services through UPMC AnywhereCare are not covered services for UPMC *for You* Members and Community HealthChoices Participants.
  - **OCN is not an affiliate of UPMC.**

Clinical and Preventive Health Care Guidelines

UPMC Health Plan strongly endorses the value of clinical practice guidelines. UPMC Health Plan routinely evaluates guidelines that are relevant to Members and critical to achieving positive health care outcomes, or that are useful in managing conditions where practice variation and differences in care can greatly affect the disease process. The UPMC Health Plan Quality Physician Advisory Council (QPAC) is responsible for guideline development and ongoing review. The QPAC also assists UPMC Health Plan, which systematically monitors adherence to practice guidelines, in identifying opportunities for improvement when nonadherence is found.

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

UPMC Health Plan reviews all practice guidelines **annually** and updates them as needed to reflect changes in recent scientific evidence or technology.

These guidelines may include:

- Adult cholesterol management.
- Attention deficit/hyperactivity disorder.
- Depression.
- Diabetes mellitus health management guidelines for children and adults.
- Evaluation and management of heart failure for outpatients.
- Management of asthma in infants, children, and adults.
- Management of hypertension.
- Prenatal care guidelines.

UPMC Health Plan **annually** reviews and updates a schedule of pediatric (**birth to age 19**) and adult **(19 years old and older)** preventive health guidelines. UPMC Health Plan encourages its providers to follow these guidelines to reduce variation in care, prevent illness, and improve Members' health. UPMC Health Plan continues to add and revise guidelines. To see the most current clinical and preventive health care guidelines, go to **upmchealthplan.com** or call **Provider Services**, Monday through Friday, from 8 a.m. to 5 p.m., for a hard copy.

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

Member and Provider Surveys and Assessments

Health Assessment Survey

UPMC Health Plan performs a health assessment survey for some UPMC Community HealthChoices (Medical Assistance) Participants, all new UPMC *for Kids* (CHIP) and UPMC *for Life* (Medicare) Members and some UPMC Health Plan (Commercial) Members, based on employer group, to determine their clinical risk for the development of chronic illness.

This tool assesses the Member's clinical status and any psychological, emotional, or environmental issues that may affect their health. This information assists in identifying high-risk Members for enrollment in case and health management programs. The survey results are sent to the appropriate provider to assist in the clinical management of these Members.

Obstetrical Needs Assessment

Ob-gyns and PCPs performing routine gynecological services should complete an **Obstetrical Needs Assessment (OBNA) Form,** which is a comprehensive assessment of the physical, psychological, and obstetrical history of a UPMC Health Plan (Commercial), UPMC *for Kids* (CHIP), UPMC *for Life* Complete Care (HMO D-SNP), UPMC Community HealthChoices (Medical Assistance), and UPMC *for You* (Medical Assistance) Members.

This information is used to identify Members at risk for complications in pregnancy and who would benefit from enrollment in the Baby Steps 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,** Monday through Friday, from 8 a.m. to 5 p.m**.**

➢ **Note:** Providers serving either Medical Assistance or CHIP Members **must** be enrolled with the Department of Human Services and possess an active PROMISe™ ID (also known as the MMIS ID) **for each** location at which they provide services.

➢ **See: UPMC Health Plan Provider Manual**

- ***Provider Services*,** Chapter A, Welcome and Key Contacts.
- ***Medical Assistance Revalidation Requirement,*** Chapter B, Provider Standards and Procedures.
- ***Provider Enrollment Alert,*** Chapter D, UPMC *for Kids.*

Closer Look at Obstetrical Needs Assessment Form

Providers should complete the OBNA form and **must** submit it electronically to UPMC Health Plan in Optum OB Care or EpicCare (EPIC).

For questions about submitting the form electronically, providers may call **Provider Services** at **1-866-918-1595,** Monday through Friday, from 8 a.m. to 5 p.m.

UPMC-owned ob-gyn providers will use EPIC. All other providers and UPMC-owned providers without EPIC will use the Optum OB Care web tool.

For questions about the form or to obtain information about using the Optum OB Care web tool, providers may also call the **UPMC Health Plan Baby Steps Maternity Program** at **1-866-778-6073.**

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 **(1-84 days after delivery)**

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 Members for the maternity program.

Providers who have questions about the form should call the **UPMC Health Plan Baby Steps Maternity Program** at **1-866-778-6073 (TTY: 711).**

A blank form, instructions, tip sheet, and DHS validated depression screening tools, can be found on **Provider OnLine** at **upmchealthplan.com/providers** under documents/forms, Maternity, Obstetrical Needs Assessment form.

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

Member and Provider Satisfaction Surveys

UPMC Health Plan conducts **annual** surveys of both Member and provider satisfaction. Participation by Members and providers enables UPMC Health Plan to develop quality improvement plans.

The surveys assess:

- Access to care and/or services.
- Overall satisfaction with the Health Plan.
- Provider availability.
- Quality of care received.
- Responsiveness to administrative processes.
- Responsiveness to inquiries.

Provider Performance Tracking

UPMC Health Plan is continuously analyzing and identifying best practices and areas of improvement regarding quality of care and cost-effectiveness. Only providers with a predetermined minimum number of UPMC Health Plan Members are profiled. These individual profiles compare providers to the performance of all other providers within their specialty and against national benchmarks. The profiles are distributed to providers **semi-annually**.

UPMC *for You* (Medical Assistance) Provider Pay for Performance

UPMC *for You* offers a Provider Pay for Performance (P4P) program in partnership with the Department of Human Services (DHS). The program is available to providers who participate with UPMC *for You* and have a minimum number of Members assigned to their practice. The P4P program offers providers the opportunity to receive incentive payments for the completion of visits, screenings, or other services related to specific HEDIS and PA Performance measures. The P4P program has both PCP and maternity related measures.

Eligible providers participating in the program will receive **monthly** rosters of Members in each P4P measure, along with information on visits, screenings, or other services that have been completed or those that still need to be completed. Claims and quality improvement data are reviewed to determine completion rates and corresponding provider incentive payments. **Within 120 days** of the completion of the **calendar year**, all incentive payments are distributed based on the approved measures and payment structure for the program year.

Ob-gyn and family practice providers (PCPs) who are credentialed to perform deliveries are eligible to participate in the maternity measures of the P4P program. All aspects of the P4P program are reviewed by UPMC *for You* on an **annual** basis and submitted to **DHS annually** for review and approval.

Quality Improvement Program

The goal of the Quality Improvement Program is to continually examine clinical and administrative operations to continuously improve UPMC Health Plan's ability to deliver high-quality, timely, safe, and cost-effective health care services.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID), and the Centers for Medicare & Medicaid Services (CMS).

The program critically assesses UPMC Health Plan's performance regarding customer service, provider satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

At the center of the program are the providers who serve on the Quality Physician Advisory Council (QPAC). The QPAC, representing both academic and community providers, provides valuable input directly under the auspices of the committees of the Quality Governance Structure ultimately reporting to the Quality Committee of the Board. The QPAC is vital to UPMC Health Plan because it develops and evaluates clinical and operational standards for providers.

The Provider Agreement requires providers to comply with UPMC Health Plan's Quality Improvement Program. To obtain additional information, providers may go online at **upmchealthplan.com/providers** or call **Provider Services,** Monday through Friday, from 8 a.m. to 5 p.m.

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