UPMC *for You* (Medical Assistance)

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At a Glance

UPMC *for You*, affiliate of UPMC Health Plan, offers high-quality care to eligible Medical Assistance recipients in **all 67 counties** in the Commonwealth of Pennsylvania. This care is achieved by combining the benefits of a managed care organization with all the services covered by Medical Assistance. All UPMC *for You* providers **must** abide by the rules and regulations set forth under the General Provision of 55 Pa. Code, Chapter 1101.



Alert—Department of Human Services Regulations

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

If providers have questions regarding UPMC *for You* coverage, policies, or procedures that are **not** addressed in this manual, they may contact **Provider Services** at **1-866-918-1595 (TTY: 711)** Monday through Friday from 8 a.m. to 5 p.m. or visit **upmchealthplan.com.**

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Medical Assistance Managed Care in Pennsylvania

Pennsylvania's Department of Human Services (DHS) contracts with managed care organizations across Pennsylvania to offer managed care to recipients of Medical Assistance under a program called HealthChoices.

HealthChoices

HealthChoices is Pennsylvania's innovative mandatory managed care program for Medical Assistance recipients. Recipients choose among physical health managed care organizations (PH-MCOs) contracted with DHS to provide at least the same level of services as offered by ACCESS, the traditional fee-for-service program. Behavioral health services are provided by behavioral health managed care organizations (BH-MCOs) that contract with DHS.

➢ **See:** ***UPMC for You (Medical Assistance) Contacts, Behavioral Health Services***, ***Table A.5,*** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts.

UPMC *for You* is one of the PH-MCOs offered to recipients in the following zones:

- **Lehigh/Capital Zone**
  Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties

- **Northeast Zone**
  Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming counties

- **Northwest Zone**
  Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren counties

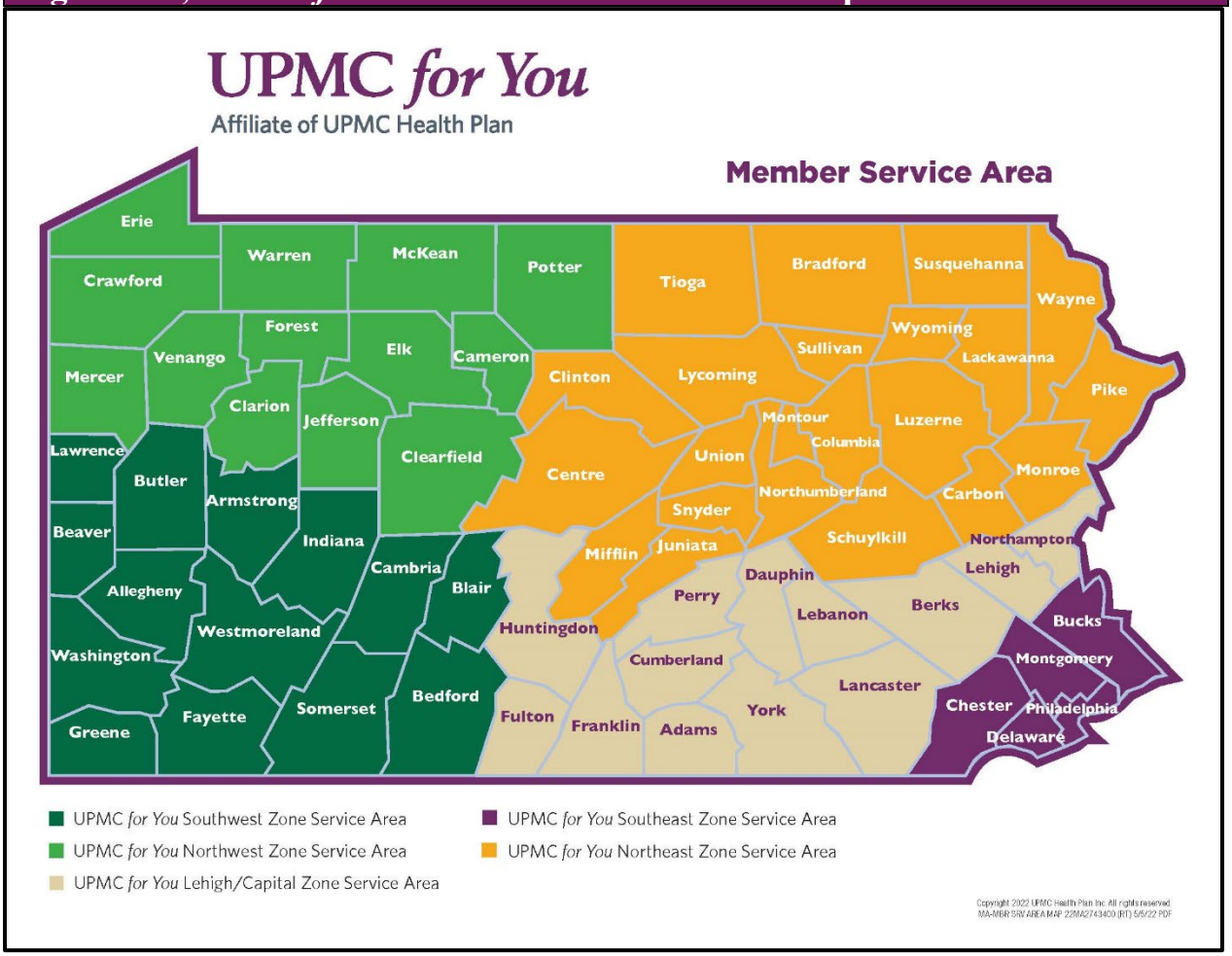
- **Southeast Zone**
  Bucks, Chester, Delaware, Montgomery, and Philadelphia counties

- **Southwest Zone**
  Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland counties

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In these counties, Medical Assistance recipients enroll in a PH-MCO, or change plans, with the assistance of independent enrollment assistance representatives. Recipients may call the **Pennsylvania Enrollment Service Consumer Support Center** at **1-800-440-3989** Monday through Friday from 8 a.m. to 6 p.m. or visit **enrollnow.net. TTY users should call toll-free 1-800-618-4225.**

Figure E.1, UPMC *for You* Member Service Area Map



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Electronic Visit Verification

UPMC Health Plan requires the use of electronic visit verification (EVV) for all Medical Assistance funded in-home personal care services (PCS), respite care services (RCS), Home Health Care Services (HHCS), and Home and Community Based Services (HCBS) provided by home health and HCBS Providers as required by the HealthChoices Agreement between UPMC Health Plan and the Pennsylvania Department of Human Services and by Section 12006(a) of the 21st Century Cures Act (42 U.S.C. § 1396b(l)).

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

- Type of service performed
- Name of the individual receiving the service
- Name of the individual providing the service
- Date of the service delivery
- Location of service delivery
- Time the service begins and ends

To meet Federal EVV compliance requirements for services on after Jan. 1, 2025, the provider must achieve **85 percent** of EVV records for verified visits **without** manual edits for PCS and HHCS. Providers rendering services to Members across multiple programs **must achieve 85 percent** of records, **without** manual edits, in each program to be considered fully compliant.

➢ **See:** ***Medical Assistance Bulletin 05-24-01*** (effective Aug. 23, 2024) and 05-25-03 (effective Aug. 29, 2025) for additional information about the EVV compliance requirements.

All data **must** be submitted following UPMC Health Plan procedures. The EVV data **may** be unedited to be considered valid. If there are any changes to the original timestamp, providers **must** also provide the following additional information:

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

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

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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.

This includes all participants/Common Law employers in Participant-Directed Services, as they will be disenrolled from Participant Directed Services if there is continued noncompliance.

DHS will provide additional information about monitoring timelines, technical assistance, corrective actions plans and penalties for not meeting manual edit thresholds. UPMC Health Plan's policies and procedures regarding EVV will be updated from time to time.

- **See:** ***Pennsylvania Medical Assistance Bulletin,*** MAB 05-24-01, 07-24-01, 54-24-05, 59-24-05, 00-24-02, dated Aug. 23,2024.

- **See:** ***Pennsylvania Medical Assistance Bulletin***, MAB 05-20-03, dated Aug. 26, 2020.

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

- **See:** ***EVV,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices.

For additional information, providers **may** contact their **physician account executive** or call **Provider Services** at **1-866-918-1595** Monday through Friday from 8 a.m. to 5 p.m.

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Covered Benefits

At a Glance

UPMC *for You* network providers supply a variety of medical services, some of which are listed below or itemized on the following pages. Some services may have copayments, require a prior authorization, have limits, or require a Benefit Limit Exception or a Program Exception. The following list is not all inclusive. For a list of UPMC Health Plan's prior authorization policies, see the UPMC Health Plan Policies & Procedures Manual, available online at **upmchealthplan.com/providers/medical/resources/manuals/policies-procedures.aspx.** For specific information **not** covered in this manual, call **Provider Services** at **1-866-918-1595 (TTY: 711)** Monday through Friday from 8 a.m. to 5 p.m.

UPMC *for You* covers:

- Allergy tests and injections.
- Cancer treatments.
- Counseling to stop smoking or using other tobacco products.
- Dental services (*benefits vary by age and prior authorization may be required*).

  ➢ **See:** ***Dental Care,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

  ➢ **See:** ***Table E.1, Dental Limits for Members 21 Years Old and Older,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

- Diagnostic tests.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Members **younger than 21 years old** (*including immunizations/vaccines*).
- Electrocardiograms.
- Emergency services.
- Gender-affirming services.
- General medical exams, office visits for obtaining a driver's license, or for participating in sports and/or camps.
- Hearing aids for Members **younger than 21 years old.**
- Home accessibility durable medical equipment.

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- Home health aide – Personal care services for Members **younger than 21 years old**, *(requires prior authorization).*
- Home health care – Intermittent skilled nursing visits to perform services such as wound care and dressing changes.
- Hospice.
- Inpatient (acute or rehab) services.
- Kidney dialysis.
- Laboratory services.
- Medical equipment and supplies.
- Medical services.
- Medically necessary services for Members **younger than 21 years old.**

  ➢ **See:** ***The EPSDT Program,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).
- Nutritional counseling.
- Occupational therapy.
- Outpatient hospital services, ambulatory surgical center, or short procedure unit.
- Outpatient services delivered at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Urgent Care Center, or Retail Convenience Care clinic.
- PCP visits (for illness or injury).
- PCP annual visit (routine physical exam, wellness/preventive visit), **one per calendar year.**
- Pediatric Extended Care Center that provides daytime skilled nursing services for Members **younger than 21 years old** as an alternative to private duty nursing, *(requires prior authorization).*
- Physical therapy.
- Prenatal care.
- Private duty nursing-skilled nursing services for Members **younger than 21 years old** *(requires prior authorization).*
- Radiation therapy.
- Speech therapy.
- Specialist visits with a verbal referral and coordinated by a PCP, (*copayments **may apply** to **chiropractor** and **podiatrist** visits*).
- X-rays.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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UPMC *for You* covers medically necessary services that are on the Pennsylvania Department of Human Services Medical Assistance Fee Schedule. Services corresponding to codes **not** on the Medical Assistance Fee Schedule **may** only be requested as a Program Exception under the Program Exception process.

➢ **See:** ***Program Exception Process*****,** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Coordinated Care

The Member's PCP **must** coordinate care. If the PCP refers a Member to an in-network specialist and also indicates a need for diagnostic testing, the Member should be directed to an in-network facility for that testing. A separate referral by the specialist is **not** required. Upon notification by the Member, family member, Member's legal designee, or a hospital emergency department, the Member's PCP **must** coordinate any care related to an emergency.

Members may self-direct their care for behavioral health services, chiropractic care, dental care, routine gynecological examinations, family planning, maternity care or prenatal visits, and vision care. To verify the coverage of any service, contact **Provider Services** at **1-866-918-1595 (TTY: 711)** or **upmchealthplan.com.**

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

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

Copayments

If UPMC *for You* imposes copayments for certain covered services and a Member **cannot** afford to pay the copayment at the time of the service, providers **must** render covered services to the Member despite nonpayment of the copayment by the Member. This shall **not** preclude providers from seeking payment for the copayments from Members after rendering covered services.

A provider **may** bill a UPMC *for You* Member for a non-covered service or item only if, before performing the service, the provider informs the Member:

- of the nature of the service;
- that the service is **not** covered by UPMC *for You* and UPMC *for You* will **not** pay for the service; and
- the estimated cost to the Member for the service.

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

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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Closer Look at a Primary Insurance Copayments

If the Member has a primary insurance and there is a copayment, coinsurance or a deductible due from the Member, that amount is included in the coordination of benefits calculation.

- If the primary insurance's payment is greater than the UPMC *for You* fee schedule payment, the provider **must** accept the primary insurance payment as payment in full. The Member would **not** be responsible for the amounts applied to a copayment, coinsurance, or deductible by the primary insurance.
- If the primary carrier's payment is less than the fee schedule, UPMC *for You* will coordinate benefits and pay up to the fee schedule amount; i.e., the primary carrier payment and the UPMC *for You* payment combined would **not** equal more than the UPMC *for You* fee schedule. The Member would **not** be liable for any copayment, coinsurance, or deductible applied by the primary insurance. The provider is required to accept the payment as payment in full and **cannot** balance bill the Member except for Medical Assistance-permitted copayments.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

➢ **See:** ***Coordination of Benefits*****,** UPMC Health Plan Provider Manual, Chapter H, Claims.

➢ **See:** ***Determining Primary Insurance Coverage*****,** UPMC Health Plan Provider Manual, Chapter I, Member Administration.

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

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

- A Member'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 Member with a difficult medical need.
- If a Member has an emergency, the provider **must** see the Member immediately or refer the Member to the emergency department.

➢ **See:** ***Table E.2, Appointment Standards*****,** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Transportation

Emergency Transportation – Ambulance

Members do **not** need prior authorization for emergency transportation related to emergency medical conditions.

➢ **Note:** Emergency and nonemergency air ambulance transportation requires authorization. Certain air ambulance services are **not covered** by UPMC *for You* and are **only covered when** an authorization is requested through the Program Exception process. Prior authorization or Program Exception authorization **must** be requested through **Provider OnLine** by accessing **upmchealthplan.com/providers.**

Nonemergency Transportation – Medically Necessary

All requests for medically necessary nonemergency transportation **must** be coordinated through **UPMC Medical Transportation** at **1-877-521-RIDE (7433)** for the following:

- Air ambulance (*requires program exception approval*)
- Ground ambulance
- Wheelchair van transportation

➢ **Note:** UPMC *for You* (Medical Assistance) providers located in the Lehigh/Capital zone **do not need** to call UPMC Medical Transportation.

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Nonemergency Transportation – Routine

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

> ➢ **See:** ***Figure E.1, HealthChoices Member Service Area map*** to determine the Members' zone service area. UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

If the Member has an unusual nonemergency transportation need due to a medical condition, the **Enhanced Member Services Unit (EMSU)** can be contacted for assistance. The **EMSU** can be reached at **1-866-463-1462 (TTY: 711)** Monday through Friday from 8 a.m. to 6 p.m.

> ➢ **See:** ***matp.pa.gov/CountyContact.aspx*** for a list of MATP providers by county.

Ancillary Services

Ancillary services, such as the following examples radiology, pathology, laboratory, and anesthesiology, are covered when coordinated by an in-network provider and rendered by an in-network provider for medically necessary services covered by the Medical Assistance fee schedule. Some services **may** have copayments and require prior authorization review.

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

> ➢ **See:** ***Appendix E.2: Copayments Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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Chiropractic Care

UPMC *for You* Members **may** self-direct to chiropractic care. Chiropractic services are covered when delivered by an in-network provider. UPMC *for You* covers medically necessary evaluations and manual spinal manipulations.

Chiropractic services for children **younger than 7 years old** require prior authorization.

The provider **must** contact **Utilization Management** for a prior authorization review of medical necessity. Providers **may** request prior authorization through **Provider OnLine** by accessing **upmchealthplan.com/providers** and entering the authorization request, including supporting clinical documentation and a Certificate of Medical Necessity (CMN).

UPMC *for You* **will not** cover x-rays when performed by a chiropractor; however, chiropractors **may** refer Members to an in-network provider for x-rays.

Copayments **may** apply for some Members **18 years old and older**.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Dental Care

All UPMC *for You* Members receive routine dental care. Additional benefits vary by age and prior authorization **may be required.** Members may self-direct their dental care to an in-network provider.

SKYGEN administers routine dental benefits including prior authorization medical necessity review for UPMC *for You* Dental Advantage Members.

- Providers may contact the **Provider Call Center** at **1-855-806-5193** or **providerservices@skygenusa.com.**

- Members may call the **UPMC *for You* Dental Advantage Health Care Concierge team** at **1-800-286-4242 (TTY: 711).**

➢ **See:** ***SKYGEN Dental Provider Manual*** at **skygenusa.com** or **upmchealthplan.com/providers/dental/skygen/default.aspx** for full details of services and the dental prior authorization process.

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Dental Advantage services for Members 21 years old and older

UPMC *for You* Members who are 21 years old and older and do not live in a nursing home or intermediate care facility (ICF) are eligible for the following services:

- **One** dental exam (oral evaluation) and cleaning (prophylaxis), **every 180 days**
  - *Additional oral evaluations and prophylaxis will require a benefit limit exception (BLE).*

- **One** partial upper denture or **one** full upper denture; and **one** partial lower denture or **one** full lower denture
  - *Service is covered **once per lifetime.***
  - *Additional dentures will require a BLE.*

  ➢ **Note:** If UPMC *for You* Dental Advantage paid for a partial or full **upper denture** since April 27, 2015, the Member can only receive another partial or full **upper denture** if they qualify for a BLE.

  ➢ **Note:** If UPMC *for You* Dental Advantage paid for a partial or full **lower denture s**ince April 27, 2015, the Member can only receive another partial or full **lower denture** if they qualify for a BLE.

The following services are **not** covered unless the Member qualifies for a BLE:

- Crowns and adjunctive services
- Root canals and other endodontic services
- Periodontal services

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

- The provider has requested an exception to the limit and the request was denied.

- The provider advised the Member, **before** the service was provided, that they will be responsible for payment if the exception is **not** granted.

- The provider advised the Member, **before** the service was provided, that the Member has exceeded the limits.

- The provider advised the Member, **before** the service was provided, and documented the discussion in the medical record. The provider **may** have the Member sign an advance notification form.

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

➢ **See: *Benefit Limit Exceptions*,**

- UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).
- SKYGEN Dental Provider Manual at **skygenusa.com** or **upmchealthplan.com/providers/dental/skygen/default.aspx.**

The following dental benefits and limits apply to Members 21 years old and older, including Members 21 years old and older who reside in personal care homes and assisted living facilities.

- The dental limits **do not** apply to:
  - Members **younger than 21 years old** or to
  - adults who reside in a nursing facility or an
  - intermediate care facility (ICF).

- Services beyond a Member's benefit limits are **not** covered unless the Member or the provider requests and receives approval for a **Benefit Limit Exception (BLE).**

- The provider **cannot** bill the Member for the non-covered services unless the Member was advised **in advance** that the service may **not** be covered and a BLE was submitted and denied.

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Table E.1: Dental Limits for Members 21 Years Old and Older

Description	Full Benefits	
	Age 21 and older ***(NOT Residing in a Nursing Facility or ICF)***	**Age 21 and older** ***(Residing in a Nursing Facility or ICF)***
Anesthesia	Covered May require prior authorization or subject to retrospective review	Covered May require prior authorization or subject to retrospective review
Checkups – *(Routine exam) (including x-rays)*	Covered – **1 per 180 days** Additional exams require a BLE	Covered – **1 per 180 days**, then requires BLE
Cleanings – *(Prophylaxis)*	Covered – **1 per 180 days** Additional cleanings require a BLE	Covered – **1 per 180 days**, then requires BLE
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 removals)*	Covered	Covered
Fillings – *(Restorations)*	Covered	Covered
Orthodontics (Braces)*	**Not covered***	Covered* Requires prior authorization
Palliative care *(Emergency treatment of dental pain)*	Covered	Covered
Periodontal services**	**Not covered**** Unless a BLE is approved	Covered** Requires prior authorization
Root canals and other Endodontic services	**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:

*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 Member remains eligible for Medical Assistance.

** Exceptions to the periodontal limits may be granted for individuals who have specials health care needs or a disability, pregnant women, individuals with coronary artery disease, or individuals with diabetes.

*** Medically necessary dental care such as:

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

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Dental Advantage services for Members younger than 21 years old

The following dental services are covered for Members **younger than 21 years old** when medically necessary:

- Anesthesia – ***May*** *be reviewed retrospectively for medically necessity*
- Cleanings – **One** routine exam **per 180 days.** A BLE can be requested if Member has exhausted their routine benefit.
- Crowns – *Requires prior authorization*
- Dental emergencies
- Dental exams (routine oral evaluations) – Covered: **one** routine exam **per 180 days,** including x-rays. A BLE can be requested if member has exhausted their routine benefit.
- Dental surgical procedures – *Requires prior authorization*
- Dentures – *Requires prior authorization*
- Extractions (impacted tooth removals) – *Requires prior authorization*
- Extractions (simple tooth removals)
- Fillings
- Fluoride and varnish treatments
- Orthodontics (braces)* – *Requires prior authorization*
- Periodontal services – *Requires prior authorization*
- Root canals – *Requires prior authorization*
- Sealants
- Sleep apnea mouthpiece – *Requires prior authorization*
- X-rays



Closer Look at Braces*

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 Member remains eligible for Medical Assistance.

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Members **younger than 21 years old** are eligible to receive all medically necessary dental services. The American Dental Association and the American Academy of Pediatric Dentistry state that the first dental visit should occur after the child's **first tooth** eruption but **no later than their first birthday.** The Member should be referred to a dental home as part of their EPSDT well-child screenings.

Providers should notify the UPMC Health Plan Public Health Hygiene Practitioner (PHDHP) Dental Care Management Team of the referral using the Dental Referral Fax form. The form is located in the EPSDT Clinical & Operational Guidelines section of the UPMC Health Plan website at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.**

The form should be faxed to the **UPMC Health Plan Clinical Operations Department (Attention: EMSU)** at **412-454-7552.** Call **1-800-899-7553 (TTY: 711)** with any questions. Forms may also be emailed directly to **UPMC*forYou*Dental@upmc.edu.** This email box is staffed by the PHDHP team.

Staff will then contact the Member or the Member's parent/guardian to assist in locating a dental home for their child(ren).

➢ **See:** ***The EPSDT Program,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Oral Health Intervention Program

UPMC *for You* has an oral health intervention program that uses PHDHP Dental Care Managers to provide oral health education, and dental home connections as well as Member outreach. UPMC *for You* encourages the provider community to refer Members and/or caregivers to the PHDHP Dental Care Management team as part of the oral health discussion at the time of a well visit for oral health education. The UPMC *for You* PHDHP Dental Care Management team has both telephonic and regional team members—the telephonic team supports Members across all counties; the regional team supports Members residing within a specific territory. The PHDHP team can be reached Monday through Friday from 8 a.m. to 4:30 p.m. at the following numbers:

Oral Health Intervention Program	
General program inquires	**upmcforyoudental@upmc.edu**
Telephonic	**1-833-776-4525** **1-833-776-4526** **1-833-854-7384** **TTY:711**

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The Department of Human Services' pediatric dental periodicity schedule provides recommendations for preventive dental care and screening recommendations for children, infancy **through 20 years old,** for the following:

- Clinical oral evaluation
  - Includes anticipatory guidance, (i.e., information/counseling given to children and families to promote oral health).

- Prophylaxis/topical fluoride treatment
  - Topical fluoride varnish can be applied by providers in a PCP setting with certification. Providers can contact their provider network physician account executive or **UPMC*forYou*Dental@UPMC.edu** for additional information.

- Radiographic assessment

- Assessment for pit and fissure sealants

- Treatment of dental disease/caries risk assessment

➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

All medically necessary EPSDT dental screenings are covered for Members **younger than 21 years old** and are based on the EPSDT Periodicity Schedule.

➢ **See:** ***The EPSDT Program,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

➢ **See:** ***Appendix E.1, Other Resources and Forms, EPSDT Periodicity Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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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. Copayments **may apply** for diagnostic services (medical or radiology diagnostic testing, nuclear medicine, and radiation therapy).

➢ **See:** ***Appendix E.2, Copayment Schedule*****,** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance*)*.

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

➢ **See: Behavioral *Health and Substance Use Disorder Services*****,** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

➢ **See: *Table A.5,* UPMC *for You (Medical Assistance) Contacts, Behavioral Health Services,*** 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 that 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)

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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 **must** 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** be currently Medicare certified.

➢ **See:** ***Medical Assistance bulletin*** **#01-12-67, 08-12-62, 09-12-63, 28-12-01, 31-13-65, 33-13-61,** effective Jan. 1, 2013, at **pa.gov/agencies/dhs/dhs-search/dhs-publications.html#q=01-12-67.**

Emergency Care

UPMC *for You* 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 Member (or for pregnant Members, the health of the Member and the 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** by accessing **Provider OnLine** at **upmchealthplan.com/providers within 48 hours** or on **the next business day** following an emergency admission that results in an inpatient hospital admission.

Members with an emergency medical condition or those acting on the Member'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 Member's PCP or from UPMC *for You.*

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Redirected Emergency Department Visit

If a Member 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 Member with any alternative care arrangements, such as an office visit or treatment instructions.

Family Planning

Members 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 *for You* Members may access 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.

Hearing Exams/Aids

Hearing exams require a PCP referral. Hearing aids are covered for UPMC *for You* Members **younger than 21 years old** when provided by an in-network provider.

Home Health Care and Shift Care Services

Home health care services:
Home health care services are covered when coordinated through an in-network provider.

Shift care services:
Shift care services require initial and ongoing prior authorization.

- Home Health Aides (for Members **younger than 21 years old**)
- Pediatric Extended Care Center services (for Members **younger 21 years old**)
- Private Duty Nursing in the home (for Members **younger than 21 years old**)

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The provider requesting prior authorization for Home Health Aide Services, Pediatric Extended Care Center services, or Private Duty Nursing for Members **younger than 21 years old must** submit a completed UPMC Health Plan medical necessity form, a Letter of Medical Necessity and all relevant clinical and social information including Member/family's school and work schedules to the Utilization Management Department through **Provider OnLine** at **upmchealthplan.com/providers.** Medical necessity forms and instructions for submitting authorization requests can be found at **upmchealthplan.com/providers/forms.**

The following services **may** require prior authorization after a standard number of visits have been exhausted:

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

The provider **must** contact **Utilization Management** to request prior authorization by submitting the request through **Provider OnLine** at **upmchealthplan.com/providers.** 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

As of 2024, Home Health Care and Shift Care services require electronic visit verification (EVV).

➢ **See:** ***EVV,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* Medical Assistance for details.

Home Accessibility Durable Medical Equipment (HADME)

UPMC *for You* will pay for the installation of medically necessary covered home accessibility durable medical equipment installed by qualified personnel and medically necessary repairs to the equipment, **but not** home modifications.

For the Member to be eligible for these services their physician or therapist **must** verify certain information in accordance with UPMC *for You* policy.

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Covered Services for medically necessary services include but are **not limited** to the following:

- Ceiling lifts
- Metal accessibility ramps
- Mobility products that are medically necessary to enter/exit the Member's home or to support mobility activities of daily living and meets the definition of 42 CFR Section 440.70 (b)(3)(i-ii)
- Stair glides
- Wheelchair lifts

Installation may include the following:

- External supports, such as bracing a wall
- Installing an electrical outlet or connection to an existing electrical source
- Labor to attach or mount the item to a surface per the manufacturer's installation guide
- Parts or supplies provided or recommended by the manufacturer for attaching or mounting the item to the surface at the home or residence
- Pouring a concrete foundation (slab) according to the manufacturer's instructions (which may include leveling the ground under the concrete foundation)
- Required permits
- Removing a portion of an existing railing or banister, only as needed to accommodate the equipment

Home modifications are **not covered.** Home modifications include:

- Modification to the home or place of residence.
- Repairs of the home, including repairs caused by the installation, use or removal of the medical equipment or appliance.
- Changes to the internal or external infrastructure of the home or residence, including:
  - Adding internal supports such that the support requires access to the area behind a wall or ceiling or underneath the floor.
  - Constructing retaining walls or footers for a retaining wall.
  - Installation of or modification of a deck.
  - Installation of a driveway or sidewalk.
  - Upgrading the electrical system.
  - Plumbing.
  - Ventilation or HVAC work.
  - Widening a doorway.
  - Drywall.
  - Painting.
  - Installation of flooring.
  - Tile work.
  - Demolition of existing property or structure.

➢ **See:** ***Medical Assistance Bulletin:*** 09-21-04,10-21-01, 14-21-01, 24-21-04, 25-21-01, 31-21-05, 33-21-04, Effective April 1, 2020.

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Home Medical Equipment (HME)

Home medical equipment (e.g., hospital beds, manual wheelchairs, walkers, respiratory equipment [including oxygen therapy]) is covered when coordinated through an in-network provider and used for medically necessary services that are on the Medical Assistance fee schedule. Some HME items are subject to a capped rental.

Specialized Home Medical Equipment (SHME)

Specialized home medical equipment, including but **not** limited to power mobility devices, (e.g., power wheelchairs and scooters); pressure reducing support surfaces; lymphedema pumps, and bone growth stimulators require a prior authorization review. SHME is covered when coordinated through an in-network provider and used for medically necessary services that are on the Medical Assistance fee schedule. The provider **must** contact **Utilization Management** for a prior authorization review of medical necessity to receive coverage of certain SHME as indicated in the online Policies and Procedures Manual found at **upmchealthplan.com/providers.** Providers **must** submit a prior authorization request through **Provider OnLine** by accessing **upmchealthplan.com/providers.** Failure to obtain authorization will result in denial of the claim.

Home Physician Visits

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

Palliative Care

Palliative care is available for qualifying Members when coordinated through an in-network provider. Palliative care services may require prior authorization. The provider **must** contact **Utilization Management** for a prior authorization review of medical necessity. Providers **may** request prior authorization through **Provider OnLine** by accessing **upmchealthplan.com/providers** and entering the authorization request.

Hospital Admissions

Admissions to hospitals are covered if medically necessary and the provider and hospital facility obtain prior authorization from UPMC *for You*. If a specialist admits the Member, the specialist should coordinate care with the Member'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.

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Some UPMC *for You* Members **18 years old or older may** have a copayment for inpatient stays.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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

Immunizations

PCPs and specialists serving UPMC *for You* Members who are **18 years old or younger** need to be enrolled in **Vaccines for Children (VFC),** a federally funded program that provides vaccines free of charge. To enroll in the **PA VFC Program,** call **1-888-646-6864** or access **cdc.gov/vaccines/hcp/admin/vfc.html.**

PCPs **may** provide other immunizations **not covered** under VFC but covered by UPMC *for You*. UPMC *for You* also covers certain adult immunization. To verify the coverage or to obtain additional information call **Provider Services** at **1-866-918-1595 (TTY: 711).**

Medical Social Services

UPMC *for You* and the provider **must** jointly address any identified social or personal needs that affect a Member's medical condition (e.g., lack of heat or water).

UPMC Health Plan offers enhanced Member support services (case management) for UPMC *for You* (Medical Assistance) Members who may have complex physical health needs, health related social needs, multiple physical or behavioral health needs, or special communication needs.

Members **may** require community services, or they may just need extra guidance in obtaining health care services. Care managers will assist with Members who may benefit from care coordination.

Care Management staff is available at **1-866-463-1462 (TTY: 711)** Monday through Friday from 8 a.m. to 6 p.m.

➢ **See:** ***Enhanced Member Supports Unit (EMSU) Services,*** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management.

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Mental Health and Substance Use Disorder Benefits

UPMC *for You* **does not manage** the Member's behavioral health benefits. These services are managed by a behavioral health managed care organization (BH-MCO) in the Member's county of residence.



Closer Look at Behavioral Health Managed Care Organizations

Providers are required to refer and coordinate a Member's care with behavioral health providers.

➢ **See:** ***Table A.5, UPMC for You (Medical Assistance) Contacts, Behavioral Health Services,*** UPMC Health Plan Provider Manual, Chapter A, Welcome and Key Contacts, for a list of BH-MCOs.

Office Visits

PCP visits are covered. Specialist visits are covered with a PCP referral and coordination. Copayments **may** apply to chiropractor and podiatrist visits for some Members. An **annual** wellness/preventive visit is covered **once per calendar year.**

➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance), for the frequency of EPSDT visits.

➢ ***See: EPSDT Periodicity Schedule*** at ***upmchealthplan.com.***

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (*Medical* Assistance).



Closer Look at Referrals

UPMC *for You* **does not require the submission of paper referral forms.**
PCPs may refer a Member to an in-network specialist following standard medical referral practices such as calling the specialist or by providing the Member a "script" or "letter" for the specialist's records.

The PCP and specialist should coordinate care. The PCP and specialist **must** contact **Utilization Management** for prior authorization approval of an out-of-network referral by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers.**

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

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Organ Transplants

Certain organ transplants are covered but require prior authorization from UPMC *for You*. Members **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 *for You* Members. Care for an emergency medical condition, provided by an out-of-network provider, is covered. Members are encouraged to notify their PCPs after they receive such care.

Medically necessary nonemergency services **may** be covered if:

- It is unreasonable to expect the Member to return to the UPMC *for You* service area for treatment and prior authorization is obtained.

- Urgent conditions that require immediate attention and for which a delay in care would result in a significant decline in the Member's health may justify out-of-area care (by an out-of-network provider).

- Medically necessary services **are not** available in the UPMC *for You* provider network and a prior authorization is obtained.

UPMC *for You* Members **are not** permitted to self-direct to out-of-network providers, except for emergency services or for family planning services; however, if an in-network provider requests to send a Member for out-of-network care the in-network provider **must** contact Utilization Management to obtain prior authorization.

The in-network provider **must** submit an out-of-network prior authorization request through **Provider OnLine** at **upmchealthplan.com/providers.** The prior authorization request will be reviewed for medical necessity.

The provider will be notified of the determination electronically by phone. If the request is denied, the provider and Member will receive written notification. The provider can appeal a denial by following the instructions outlined in the denial letter.

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Alert—Out-of-Network Care Referrals

To send Members to out-of-network specialists or facilities, the in-network provider **must** obtain prior authorization by contacting **Utilization Management** and submitting an out-of-network prior authorization request through **Provider OnLine** at **upmchealthplan.com/providers.** Failure to obtain authorization will result in denial of the claim. The referring provider **must** give the medical necessity reason 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 of Medicaid funds to institutions or entities located outside of 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 Member's PCP and contact **Utilization Management** to obtain authorization for procedures as appropriate. Providers **may** request prior authorization by logging on to **upmchealthplan.com/providers** and entering the authorization request through **Provider OnLine.**

Podiatric Care

Medically necessary podiatric care is covered with a referral from the Member's PCP. Copayments **may** apply for some Members.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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Prescription Drug Coverage

The UPMC *for You* prescription plan features a two-tier formulary—one tier for generic medications and another tier for brand-name medications. UPMC *for You* **must** also use the Pennsylvania Medical Assistance Statewide Preferred Drug List (PDL) as required by the Department of Human Services (DHS), for certain medication classes.

The statewide PDL is a list of drugs and drug classes developed by DHS. Quantity limits, once-daily dosing, benefit exclusions, copayments, and prior authorization programs **may** apply.

The plan covers some over-the-counter products, when written on a prescription, including smoking cessation aids and birth control. Members **must** use the UPMC *for You* pharmacy network. Based on the Member's Medical Assistance category, copayments **may** apply.

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



Closer Look at Prescription Drug Coverage

Providers who have questions about prescriptions should contact **Pharmacy Services** at **1-800-979-UPMC (8762) (TTY: 711)** Monday through Friday from 8 a.m. to 5 p.m.

UPMC *for You* Members can receive a **90-day supply** of some maintenance medication prescriptions for the cost of **one copayment** through the **90-day** retail pharmacy program.

➢ **See:** ***Where to Obtain Prescriptions,*** 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 **may** require prior authorization.

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

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Rehabilitative Therapy

Inpatient

Inpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the Member'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. Copayments for some Members **age 18 and older** may apply.

Outpatient

Medically necessary outpatient rehabilitative therapy (occupational, physical, respiratory, and speech) is covered when coordinated through the Member's PCP and delivered by an in-network provider. All outpatient rehabilitation visits require a referral from the PCP and copayments may apply.

> ➢ **Note:** Physical Therapy **may** require prior authorization after a standard number of visits have been exhausted.

> ➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (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 regardless of 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 Member's medical record and a copy submitted with the claim.

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Cases of Rape and Incest
In cases of rape or incest, the Member **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 Member:

- Was a victim of rape or incest.
- Reported the incident, including the identity of the offender, if known, to the appropriate law enforcement agency or county child protective service agency (in incest cases where the Member is a minor). 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 Member 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 Member may request one through her PCP or ob-gyn provider. The provider and Member **must** complete a **Patient Acknowledgement for Hysterectomy form (MA-30).** The consent form **must** be maintained in the Member'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 Member **must** voluntarily give informed consent to the procedure. The Member also **must** be **at least 21 years old** at the time she gives informed consent and **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 Member's medical record and a copy of the form **must** be submitted with the claim.

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Vasectomy

A vasectomy is covered when coordinated through a PCP and performed by an in-network provider. The Member **must** voluntarily give informed consent to the procedure.

The Member also **must** be **at least 21 years old** at the time he gives informed consent and 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 Member's medical record and a copy of the form **must** be submitted with the claim.



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

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

➢ **Note:** Providers **may** order consent forms from the Office of Medical Assistance Programs (OMAP) at **expressforms.pa.gov/apps/pa/DHS/MA- Provider.** Questions about forms should be directed to **OMAPFormsRequiest@pa.gov.**

Skilled Nursing Facility Care

Skilled nursing facility care is covered if the treating provider obtains prior authorization, and the care is medically necessary and provided in a licensed facility.



Closer Look at Skilled Nursing Facility Care

UPMC *for You*'s responsibility to provide benefits for Members who enter a licensed skilled nursing facility continues up to the date prior to the Community HealthChoices (CHC) start date.

UPMC *for You* provides skilled nursing facility care benefits for Members who enter a licensed skilled nursing facility for the **first 30 days** of the Member's stay. UPMC *for You* will continue to pay **past day 31** and onward until the day the Member is determined to be eligible for Community HealthChoices (CHC), assuming the Member remains in the nursing facility.

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➢ **For example**:
The Member is admitted to a nursing facility on April 1.
UPMC *for You* will pay the **first 30 days** (April 1 to April 30).
The Member remains in the nursing facility **beyond 30 days** and is determined eligible for CHC on June 15; UPMC *for You* will be responsible for payment from May 1 to June 14. CHC will begin paying the nursing facility on June 15.

If the Member **is not determined eligible** for CHC while they are still in the nursing facility, UPMC *for You* will be responsible for payment from **day 1 to 30** and from **day 31** onward until the Member leaves the facility, even if the Member is **not** determined eligible for CHC.

Providers **must** notify **Utilization Management** at **1-800-425-7800 (TTY: 711)** if the Member has remained in the skilled nursing facility **beyond 30 days.**

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 Member 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 *for You.* The out-of-network provider **must** obtain prior authorization by contacting **Utilization Management** at **1-800-425-7800 (TTY: 711).**

Therapy

Outpatient therapy (chemotherapy, dialysis, and radiation) is covered with a prescription when performed at an in-network facility. Copayments **may** apply for some Members.

➢ **See:** ***Appendix E.2, Copayment Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Urgent Care

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

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Closer Look at Urgent Care

If the Member is unable to call the PCP before going to the emergency department and the Member 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 Member should attempt to contact **Provider Services** at **1-866-918-1595.** If the emergency department cannot reach UPMC *for You,* it should provide the service and attempt to contact the PCP or UPMC *for You* afterward.

Routine Vision Benefits

Routine Vision benefits are administered by **Envolve Vision**. Benefit coverage varies by age. Providers and Members may contact **Envolve Vision** directly for additional information.

Envolve Vision's Provider and Customer Services contacts for:	
UPMC *for You* (Medical Assistance) **Hours:** Monday through Friday from 8 a.m. to 7 p.m.	**1-866-458-2138** **(TTY:711)**

Members 21 years old and older receive:

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

Members younger than 21 years old receive:

- Routine vision exams **twice a year;** additional examinations in that year require prior authorization.
- A **$100 allowance** toward eyeglasses or contact lenses and fitting. If the Member chooses standard eyeglasses or contact lenses that are within the allowance, there is **no cost** to the Member. If the cost exceeds the allowance, the Member will be responsible for any cost **over the $100.**

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- **Two frames and four lenses per year** (from prior service date).

  ➢ **Note:** The **second** pair of glasses is available if medically necessary.
  - Example: The Member's prescription changes.
  - Exception to limits can be made if medically necessary and written documentation is provided.

- Replacement of eyeglasses or contact lenses if they are broken or lost, or if there is a prescription change, provided written documentation of the necessity of the service is submitted by the provider.

- Eyeglasses and all other vision services deemed medically necessary provided written documentation of the necessity of the service is submitted by the provider.

Women's Health

Family Planning

Members may self-direct care to any in-network or out-of-network provider 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.

➢ **See:** ***Covered Services – Family Planning, for full details.*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Ob-Gyn Services

- **Nonroutine**
  Members with women's health problems may self-direct care to an in-network ob-gyn.

- **Routine**
  Members **may** self-direct care to an in-network ob-gyn provider for routine annual gynecological exams and obstetrical care.

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Pregnancy Care

Members can self-direct care to an in-network ob-gyn provider for maternity care and prenatal visits. The ob-gyn provider **must** notify the Member's PCP in writing that the Member is receiving maternity care. UPMC *for You* offers pregnant Members the **UPMC Health Plan Baby Steps Maternity care management program,** which provides patient-centered support and education throughout the prenatal and postpartum period. Maternity Care Managers and Health Managers, who are experienced Registered Nurses and Licensed Social Workers, provide support, education, coordination of care, and referrals to a variety of resources to address identified Member needs. Interactions are available by telephone, face-to-face, and/or **24/7 video visits.**

➢ **See:** ***24/7 video visits*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* Medical Assistance.

Face-to-face in-home visits by mobile maternity care management staff are available in certain geographic regions. They focus on helping Members achieve and maintain a healthy pregnancy and safe delivery with an emphasis on the psychosocial and socioeconomic issues that could affect a pregnancy. The mobile maternity staff are available to answer Members' questions, provide education, and remove barriers to care in a variety of community settings such as a Member's home, provider offices or other location within their local community.



Closer Look at Health Coaches

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

Members should be encouraged to call UPMC *for You* and enroll in the **UPMC Health Plan Baby Steps Maternity Program.** Members who participate in the program and regularly attend prenatal visits are eligible for a baby gift incentive. This program rewards participation in ongoing care and addresses safe travel for the baby. Enrollees who meet the following criteria may be eligible to receive their choice of a baby gift bundle available through an online platform facilitated by **Cribs for Kids.**

- Prenatal care prior to **13 weeks**
- Enrollment in the UPMC Health Plan Maternity Program
- Compliance with lab testing as recommended by provider
- Compliance with all prenatal care visits
- Participation in all scheduled contacts by maternity program staff

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Postpartum Care

The postpartum period **(12 months after delivery)** is an extremely important time for the well-being of the parent and baby. UPMC *for You* supports the proactive scheduling of the postpartum office visit(s) **within 1 to 84 days** after the baby's birth. Additionally, UPMC *for You* pays for postpartum home health visit(s) for all UPMC *for You* Members.

Obstetrical Needs Assessment Form

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 the Member. This information will be used to identify Members at risk for complications in pregnancy and who would benefit from enrollment in the UPMC Health Plan 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, contact **Provider Services** at **1-866-918-1595** 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.
- **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:** ***Medical Assistance Revalidation Requirement****,* UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

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.** For questions about submitting the form electronically, providers **may** call **Provider Services** at **1-866-918-1595** or the **UPMC Health Plan Baby Steps Maternity Program** at **1-866-778-6073 (TTY:711).**

All OB providers will utilize the **Optum OB Care web tool.** For questions about the form or to obtain information about using the **Optum OB Care web tool,** providers **may** also contact the **UPMC Health Plan Baby Steps Maternity Program** at **1-866-778-6073 (TTY: 711).**

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

- Initial visit (optimally **prior to 13 weeks** gestation), and
- After the postpartum visit (**1-84 days** after delivery), and
- With any change in condition or risk level.

An updated OBNA submission **between 28 and 32 weeks** is strongly encouraged.

In addition, the OBNA should be updated as applicable for any change in the Member's OB status, (i.e., 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 Members for the UPMC Health Plan Baby Steps maternity program.

For questions about the form contact 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 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 Members for depression both prenatally and during the postpartum period **(12 months after delivery)** 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 **Medical Provider Resources** section at:
upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx

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

➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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Other Services

Other services available to UPMC *for You* Members include:

Health Management Programs

UPMC *for You* offers several health management programs, including asthma, cardiovascular disease (coronary artery disease and congestive heart failure), chronic obstructive pulmonary disease, and diabetes **at no cost** to the Member. Health coaches are available to answer Members' questions and offer support and advice between their visits. Information about the programs is available at **1-866-778-6073 (TTY: 711)** Monday through Friday from 8 a.m. to 6 p.m.

Health management programs are an important component of UPMC *for You*'s efforts to improve Members' health by providing intensive care management for Members with specific chronic illnesses.

The goals are to improve clinical outcomes and improve quality of life. The program is structured to identify and outreach to Members with chronic conditions. Nurse Care Managers will 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 their condition are 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 (nurses, social workers, dietitians, exercise physiologists, counselors, and health educators), in collaboration with the Members' providers, work to accomplish these goals through Member education, coordination of care, and timely treatment.

UPMC *for You* offers the following types of health education classes:

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

Contact the **Health Management Department** at **1-866-778-6073 (TTY: 711)** for information on education classes.

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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.

There are also programs to assist with lifestyle risk goals such as smoking/tobacco cessation, weight management, nutrition, stress management, and physical exercise. Members enrolled in these programs receive educational materials and have frequent clinical sessions with their health coach.

Providers who serve Members who would benefit from these health management programs should contact **Health Managemen**t at **1-866-778-6073 (TTY: 711)** for information and enrollment. Health Management staff members are available Monday through Friday from 8 a.m. to 6 p.m.

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

UPMC *My*Health 24/7 Nurse Line

This is a **24/7** advice line for Members seeking general health advice or information about a specific medical issue.

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

The **UPMC *My*Health 24/7 Nurse Line** is available for medical questions concerning both adults and children. The Member may call **1-866-918-1591 (TTY: 711)** anytime or log into **UPMC Health Plan member site at upmchealthplan.com.**

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

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24/7 Video Visits

Video visits offers Members access to high-quality care from the comfort of their home, **24/7.** With **24/7** video visits, Members of all ages can get the virtual care and advice they need for nonemergency conditions—such as rashes, sore throats, colds, and more— in the UPMC Health Plan member site and app. They can talk with UPMC providers to get a diagnosis and treatment plan right from their smartphone, tablet or computer with a webcam or microphone. Registering for a UPMC Health Plan digital login is easy at **upmchealthplan.com.**

➢ **Note:**

- **24/7** virtual visits **are not covered** services for UPMC *for You* Members using Talk Therapy or Psychiatry services.
- 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
- **24/7** video visits for children ages **0-2 are not** available from 9 p.m. to 8 a.m. or outside of Pennsylvania.
- Providers **are not available** to treat members who are in Puerto Rico.
- 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.

➢ **OCN is not an affiliate of UPMC.**

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

If a Member, upon enrolling in UPMC *for You*, is receiving services authorized by another Physical Health Managed Care Organization (PH-MCO) or by the Medical Assistance fee-for-service (FFS) program (ACCESS), those services will continue for the length of time, quantity of services, and scope of services specified by the approved prior authorization. The length of time that the service will continue will vary depending on if the Member is **younger or older than 21 years old** and/or the Member is pregnant. However, the provider still **must** notify UPMC *for You* with information regarding those services. Contact **Utilization Management** at **1-800-425-7800.**

Members younger than 21 years old:

The Member will continue to receive any prior authorized service until the end of the time period previously authorized.

Members 21 years old and older:

The Member will continue to receive any prior authorized service **up to 60 days** after enrollment with UPMC *for You*. 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.

For Members who are pregnant:

If a pregnant Member is already receiving care from an out-of-network ob-gyn provider at the time of enrollment with UPMC *for You,* the Member 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.



Closer Look at Services Already Approved by Another PH-MCO or Fee-for-Service

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

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

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Services Not Covered

Not all services are covered under the UPMC *for You* program unless requested as a Program Exception and prior authorization is obtained from Utilization Management**.** Providers **must** contact the **Utilization Management Department** 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.

➢ **Note:** Members **younger than age 21** are eligible for Medically necessary services required to treat conditions detected during a visit.

The following list contains examples of non-covered services but is not an all-inclusive list.

- Acupuncture
- Behavioral health services covered by a Member's Behavioral Health Managed Care Organization (BH-MCO)
- Experimental or investigative treatments
- 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 Member
- Nonmedically necessary treatments or surgery (e.g., cosmetic surgery)
- Out-of-country care (services provided outside the U.S.)

  ➢ **See:** ***Out-of-Area or Out-of-Network Care***, UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

- Out-of-network care (except for emergency services and family planning)
- Procedures or services **not** on the Medical Assistance fee schedule
- Self-directed care, except as noted in the Coordinated Care section

  ➢ **See:** ***Coordinated Care,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

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Program Exception Process

The program exception process occurs when a provider requests a Utilization Management review of a service which is included in the Member's benefit package but is **not** currently listed on the MA Program fee schedule to determine if an exception should be made based on medical necessity. The process also applies to benefit limit exception requests for additional treatment for a Member who has exhausted the benefit limit (i.e., duration or quantity) of a particular service.

The Utilization Management Department will consider requests by providers for program exceptions and benefit limit exceptions for UPMC *for You* Members.

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

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

A provider or the provider on behalf of the Member **must** submit the following information to request an exception:

- Member's name
- Member's address and telephone number
- Member's UPMC *for You* Member ID
- A description of the service for which the provider or the Member 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 **may** request a program or benefit limit exception before or after the service has been delivered. A Member **may** only request a benefit limit exception before the service is delivered.

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

If a service that is **not** on the fee schedule or normally requires prior authorization is delivered in an emergency, UPMC *for You* will respond **within 30 days** upon receipt of the request. An exception request made after the service has been delivered **must** be submitted by the provider through the provider appeal process **no later than 30 days** from the date UPMC *for You* rejects the claim. Exception requests made **after 30 days** from the claim rejection date will be denied.

Both the Member 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 recipient 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 Member liable for payment and bill the Member for services that exceed the limits unless the following conditions are met:

- The provider advised the Member, before the service was provided, that the Member has exceeded the limits.
- The provider advised the Member, before the service was provided, that they 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 Benefit Limit Exceptions

Benefit Limit Exception:
An exception to service limits may be granted if the UPMC *for You* Member:

- Has a serious chronic illness or other serious health condition, and without the additional service, the Member's life would be in danger; or
- Has a serious chronic illness or other serious health condition, and without the additional service, the Member's health will get much worse; or
- Has to go into a nursing home or institution if the exception is **not** granted; or
- Needs a more costly service if the exception is **not** granted.

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Closer Look at Dental Benefit Limit Exceptions

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

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

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

- Cancer of the Face, Neck, and Throat (does **not** include **stage 0 or stage 1** noninvasive basal or sarcoma cell cancers of the skin)
- Coronary Artery Disease or risk factors for the disease
- Diabetes
- Intellectual Disability
- Current Pregnancy only through the end of the postpartum period **(12 months after delivery)**

If the condition was previously identified on a claim, UPMC *for You* will **not** require supporting medical record documentation of the condition. If the condition was **not** previously identified on a claim, UPMC *for You* 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 14 days** of UPMC *for You's* 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 Member 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 Member maintains MA eligibility and only until the end of the postpartum period **(12 months after delivery)** for a pregnant Member.

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

Program exception requests should be submitted to Utilization Management by the provider along with supporting information demonstrating the medical necessity of the exception. A medical director will review all requests for program exceptions to determine medical necessity. Members may request their provider to initiate a program exception on their behalf. Members can contact the UPMC *for You* Health Care Concierge team if they need assistance or have any questions on how to request a program exception.

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

Prior to issuing a medical necessity denial letter for Members **younger than 21 years old,** the medical director will make a reasonable effort to outreach to the ordering provider **at least three times** to attempt to obtain additional information to support medical necessity.

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

Prior to issuing a medical necessity denial notice for Members **younger than 21 years old,** the medical director will make a reasonable effort to outreach to the ordering provider **at least three times** to attempt to obtain additional information to support medical necessity.

Continuation of Service requests are requests for services that a Member is currently receiving. If the medical director's medical necessity review results in termination or reduction of the service, the effective date of the termination of those services will be **15 days** from the date of the denial letter.

The services will continue at the previously approved level if the Member requests an appeal **within the 15 days** from the date of the denial notice. The previously approved level of service will continue until the appeal decision is rendered.

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The EPSDT Program

At a Glance

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides comprehensive preventive, acute, and chronic care services for children **younger than 21 years old** who are eligible for Medical Assistance.

The program provides comprehensive health services and focuses on early identification and treatment of health conditions, with a special emphasis on preventive care through regular well-child visits with a PCP. Services covered under EPSDT include but are **not** limited to well-child visits, immunizations, developmental screenings, depression screening, dental and vision screening, etc.

Services covered can be found on the EPSDT and Dental Periodicity Schedules.

- **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E UPMC *for You* (Medical Assistance).
  - ***EPSDT Periodicity Schedule***
  - ***Preventive Pediatric Oral Health Care (Dental Schedule)***

If the provider is unable to obtain sufficient information to bill the Member's primary insurance, UPMC *for You* may act as the primary carrier for EPSDT services. If, however, a claim is received with another insurance carrier's explanation of benefits (EOB) or explanation of payment (EOP), UPMC *for You* will coordinate benefits.

- **See:** ***Determining Primary Insurance Coverage*****,** UPMC Health Plan Provider Manual, Chapter I, Member Administration.
- **See:** ***Coordination of Benefits,*** UPMC Health Plan Provider Manual, Chapter H, Claims Procedures.

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Provider Responsibilities in the EPSDT Program

All UPMC *for You* providers **must** comply with the following responsibilities:

- Providers **must** make reasonable efforts to obtain information regarding all insurances the Member may have. Medical Assistance is generally the payer of last resort. If a UPMC *for You* Member has other insurance that would be primary to Medical Assistance, claims **must** be submitted to the primary insurance. The remaining balance can be submitted to UPMC *for You* for consideration and coordination of benefits. If the provider is unable to bill the primary insurance due to lack of information, UPMC *for You* will act as the primary carrier for EPSDT services and coordinate with the primary insurer, as appropriate.

  > ➢ **Note:** This process applies to preventive pediatric care and treatment (including EPSDT services to children), and services to children having medical coverage under a Title IV-D child support order.

- Provide primary and preventive care and treatment to UPMC *for You* Members.
- Act as a Member advocate by providing, recommending, and arranging for medically necessary care.
- Maintain the continuity of care for each Member in their care.
- Coordinate the Member's physical and behavioral health care needs.
- Provide referrals for any medical services that **cannot** be provided by the PCP, including referrals for in-network specialists and obtaining authorization for out-of-network care.

  - Refer the Member to a dental home by **age 1** and notify the UPMC Public Health Dental Hygiene Practitioners (PHDHP). Referrals to the UPMC PHDHP team can be made:
    - online by completing the PHDHP form
    - by fax through or by completing the form found at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx,**
    - or by notifying the PHDHP team at **UPMCforYouDental@upmc.edu.**

- Refer the Member to the Pediatric Care Management Department, as needed, to address coordination of care and resource needs of the Member. Contact the **Pediatric Care Management Department** at **pedscasemanagement@upmc.edu** or by calling **1-855-772-8762 (TTY: 711).**
- Locate, coordinate, and monitor all primary care and other medical and rehabilitative services for Members.

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- Perform and report all EPSDT screens in the appropriate format, including all applicable procedure codes and modifiers in accordance with the UPMC Health Plan EPSDT Periodicity Schedule located at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.**

- Perform and report all EPSDT immunizations in the appropriate format, including all applicable procedure codes and modifiers in accordance with the Centers for Disease Control and Prevention Child and Adolescent Immunization Schedule located at **cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html.**

- Contact Members who are **not** compliant with the EPSDT periodicity and immunization schedule, as indicated on the UPMC *for You* EPSDT **quarterly roster.** PCPs should contact Members **within one month** of the noncompliance to schedule an appointment. PCPs also should document the reason for noncompliance and that efforts have been made to bring Members into compliance. Members who are noncompliant may be referred to a **care manager** by contacting the **Pediatric Care Management Department** at **pedscasemanagement@upmc.edu** or by calling **1-855-772-8762 (TTY: 711).**

  ➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You (*Medical Assistance).
  - ***EPSDT Periodicity Schedule***
  - ***Preventive Pediatric Oral Health Care (Dental Periodicity Schedule)***



Closer Look at the Quarterly EPSDT Roster

An EPSDT roster is sent **quarterly** to any provider who has a UPMC *for You* Member **younger than 21 years old.** This roster contains information on Members who are due and overdue for an EPSDT screening.

If a provider is **not** utilizing the rosters to determine needed outreach and has opted to suppress the receipt of the rosters, an alternative process **must** be put in place to contact Members who are due or overdue for their screenings. Contact **Provider Services** at **1-866-918-1595 (TTY: 711)** for assistance to receive the rosters or set up an alternative process.

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

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- Provide childhood lead poisoning prevention services in accordance with DHS's EPSDT program requirements and lead screening guidelines established by the Centers for Disease Control and Prevention (CDC). According to the EPSDT Periodicity Schedule, a child should have a blood lead test **between 9 and 11 months** and again at **24 months.** Care for any Member with an elevated blood lead level **(3.5 µg/dL or greater)** should be coordinated with the Pediatric Care Management Department. Providers should contact the **Pediatric Care Management Department** at **pedscasemanagement@upmc.edu** or by calling **1-855-772-8762 (TTY: 711).**

- Coordinate and monitor the care provided to Members by other health care practitioners.

- Maintain a centralized and current medical record, including documentation of all services provided as well as referrals to specialists.

- Screen for developmental, behavioral, and social delays in accordance with the EPSDT Periodicity Schedule by using a standardized, validated screening tool **on or before the first, second, and third birthdays.** Maintain a copy of the completed validated tool within the Member's medical record. Examples of validated tools can be found at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.**

- Screen for autism in accordance with the EPSDT Periodicity Schedule by using a standardized, validated screening tool at **18 months and 24 months**. Maintain a copy of the completed validated tool within the Member's medical record. Examples of validated tools can be found at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.**

- In cases of suspected developmental delay, autism, or elevated blood lead levels, the PCP **must** refer the child for Early Intervention Services, by contacting **CONNECT** at **1-800-692-7288 (TTY: 711)** or by completing the Early Intervention referral form located on the UPMC Health Plan website at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.** The referral **must** be documented in the medical record. Providers may contact the **Enhanced Member Supports Unit (EMSU)** at **1-866-864-1462** to discuss next steps for children **0-5 years old.**

- Arrange care management services for Members with complex medical needs, including serious multiple disabilities or illnesses. Contact the **Pediatric Care Management Department** at **1-855-772-8762 (TTY: 711)** or by email at **pedscasemanagement@upmc.edu.**

- When appropriate, provide the Member or the Member's parent (or guardian) with information on how to access Behavioral Health services.

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- Assess for child abuse or neglect and report any suspected cases of abuse or neglect by calling **Child Line** at **1-800-932-0313 (TTY: 711)** and inform the appropriate county Children and Youth Agency. Additional resources can be found at the DHS website: **pa.gov/agencies/dhs/resources/keep-kids-safe.html.**

- Assist Members who are receiving care in a pediatric care environment with transition planning to the adult health care system, as appropriate. Assistance includes but is **not** limited to:
    - Help with coordinating transition from pediatric specialists to adult specialists.
    - Coordinating care needs for supportive services transition.
    - Moving from pediatric practice to adult practice.
    - Supporting skill building for accessing adult health care.

EPSDT Appointment Scheduling and Outreach

UPMC *for You* conducts outreach to Members eligible for EPSDT screenings. Outreach includes:

- Contact new Members or their parent or guardian to provide education on preventive health and wellness including well child visits and immunizations.
- Assist the Member with scheduling an appointment with the PCP or other appropriate provider if due or overdue for care.
- Assist Members/caregivers with scheduling dental care appointments.
- Assist in scheduling a new Member exam **within 45 days** of enrollment with UPMC *for You*, according to the periodicity schedule, unless the child is already under the care of a PCP and is current with screens and immunizations.

➢ **See:** ***Appendix E.1, Other Resources and Forms, EPSDT Periodicity Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

In situations where Members continue to be noncompliant with making or keeping EPSDT screening appointments, UPMC *for You* also will attempt other outreach methods.

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EPSDT Services

Under Pennsylvania and federal laws, the EPSDT program **must** provide the following services according to a periodicity schedule developed by DHS as recommended by the American Academy of Pediatrics.

- Screening services, including a comprehensive health and developmental history, developmental assessment, nutritional assessment, and all appropriate immunizations per CDC guidelines
- An unclothed comprehensive physical examination
- Calculation of body mass index and growth chart percentile
- Health education and guidance: age-appropriate nutritional counseling, anticipatory guidance/risk factor reduction interventions
- Ordering of appropriate laboratory tests, including hemoglobin and hematocrit, dyslipidemia, urinalysis, iron levels, TB skin testing, sickle cell anemia screening, and lead levels
- Newborn metabolic/hemoglobin screening and follow-up consistent with the Pennsylvania Newborn Screening Panel: newborn bilirubin screening, growth measurements and head circumference
- Psychosocial/Behavioral assessments: behavioral health services, including counseling. Assessment should be family centered and may include an assessment of the child's social-emotional health, health related social needs, (HRSN) and caregiver anxiety/depression/substance use disorder
- Maternal depression screening: administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized screening tool that is most suitable for the provider's practice
- Referral to behavioral health or medical providers to correct or ameliorate any problems discovered upon the screen, including those **not** covered on the Medical Assistance fee-for-service program
- Regular depression screening during adolescence
- Teenage pregnancy services or referral for those services
- Tobacco, alcohol, and drug use assessment
- Screening for sexually transmitted infections (STI)

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- Testing for HIV and annual reassessment, per the EPSDT Periodicity Schedule, and for those at increased risk for HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs

- Vision services, including diagnosis and treatment for defects in vision, and eye exams for the provision of glasses. Screening for visual acuity using traditional methods (e.g., Snellen chart) or instrument-based screening for visual acuity and other ocular risk factors. Instrument-based screening may be completed to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional screening.

- Hearing services, including diagnosis and treatment for defects in hearing, and testing or the provision of hearing aids. Newborns should receive a hearing screening prior to their discharge from the hospital. A hearing screening is to be performed during the newborn screening and if **not**, **must be completed by age 3 months.**

- Ordering of all other medically necessary health care, diagnostic services, and treatment measures

- Dental screening, including diagnosis and treatment of dental disease, **no later than age 1.** PCPs should conduct an oral exam as part of the comprehensive examination. Administration of oral health risk assessment and assessment of the need for fluoride supplementation. Determination of whether the individual has a dental home or if a referral is needed.

  ➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).
  - ***Preventive Pediatric Oral Health Care (Dental Periodicity Schedule)***

- Autism screening utilizing a standard screening tool

  ➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).
  - ***Validated Screening Tools for Autism Spectrum Disorder***

- Developmental screening, utilizing a standard screening tool

  ➢ **See:** ***Appendix E.1, Other Resources and Forms,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).
  - ***Validated Screening Tools for Developmental Delays***

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Services are provided under the direction of the individual's PCP. When possible, it is preferable for the child to receive the examination and treatment from the same provider. If the PCP is unable to perform an examination or treatment, the provider **must** arrange for the services to be performed by another in-network provider. The PCP **must** coordinate and monitor the care provided by other practitioners and maintain a centralized medical record.

A complete listing of services, schedule, guidelines, and other information can be found on the UPMC Health Plan website and within Medical Assistance bulletins.

➢ **See:** ***Appendix E.1, Other Resources and Forms*****,** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

Initial EPSDT Visits for Newborns

The first EPSDT visit should be the newborn physical exam in the hospital, providing that it includes all the screening components.

The first follow-up visit for the newborn should be provided **within three to five days** after discharge from the hospital.

Diagnosis and Treatment in the EPSDT Program

If a screening examination or an encounter with a health professional results in the detection of a suspected problem, the child **must** be evaluated as necessary for further diagnosis and treatment.

The EPSDT program covers the provision of all medically necessary health care services required to treat a condition diagnosed during an encounter with a health care professional.

If a provider suspects developmental delay or autism, the provider **must** refer the child for Early Intervention Services by contacting **CONNECT** at **1-800-692-7288 (TTY: 711)** and should complete the **Pediatric Care Management Early Intervention** referral form located on the UPMC Health Plan website at **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx.**

If a provider detects elevated blood lead levels, the provider **must** coordinate care with the **Pediatric Care Management Department** at **1-855-772-8762 (TTY: 711)** or by email at **pediatriclead@upmc.edu.** A referral to **CONNECT** at **1-800-692-7288** should be made as appropriate.

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Closer Look at Providing Services to SSI or SSI-Related Members

At the first appointment following enrollment of a Supplemental Security Income (SSI) Member or SSI-related Member (i.e., spouse and dependents), the PCP should conduct a complete assessment to determine the child's health care needs over an appropriate period **(not to exceed one year).**

The initial appointment should occur **within 45 days** of enrollment with UPMC *for You*, unless the Member already is receiving care with a PCP or specialist.

The assessment should include the child's need for specialty care, which will be discussed with the caregiver; custodial agency and, when age-appropriate, the child. This assessment becomes part of the child's medical record.

The PCP, at the time of the initial exam, **must** make a recommendation regarding care management services. With the caregiver's or custodial agency's consent, the PCP should contact **Pediatric Care Management Department** at **1-855-772-8762 (TTY: 711)** with a referral for care management services.

Childhood Lead Poisoning Prevention

Providers should administer childhood lead poisoning prevention services according to current guidelines from the Centers for Disease Control and Prevention, which sets the standard for comprehensive childhood lead poisoning prevention services.

PCPs should conduct blood lead testing or refer the testing to a participating laboratory in accordance with the EPSDT Periodicity Schedule. Children with elevated lead levels should be identified on the CMS-1500 claim form utilizing the appropriate diagnosis code and EPSDT modifiers. PCPs who discover Members **younger than 21 years old** with blood lead levels **equal to or greater than 3.5µg /dL** should order an Environmental Lead Investigation (ELI) and contact the **EMSU** at **1-866-463-1462 (TTY: 711).**

UPMC *for You* pays for environmental lead investigations (ELIs) for children with a blood lead **levels equal to or greater than 3.5µg /dL (measured by venous blood lead level).** An ELI is an in-home assessment to determine if the cause of lead is within a Member's home. To order an ELI a provider **must** complete and submit the ELI request form found at: **upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines** and return to **pediatriclead@upmc.edu**

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Environmental lead investigation is completed in accordance with the PA Department of Health recommendations. Environmental lead investigators possess current certification from the Pennsylvania Department of Labor and Industry as an environmental risk assessor or a lead inspector.

Care Management services are available to any Member/family with an elevated blood lead level. To refer a Member/family to care management services contact the **Pediatric Care Management Department** at **1-855-772-8762 (TTY: 711)** or outreach to **pediatriclead@upmc.edu.**

- **See:** ***Appendix E.1, Other Resources and Forms, EPSDT Periodicity Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

- **See:** ***Medical Assistance bulletin #01-18-10***, Environmental Lead Investigation, effective 8-22-2018.



Closer Look at High Lead Levels

PCPs who discover Members **younger than 21 years old** with blood lead levels equal to or **greater than 3.5µg /dL** should order an environmental lead investigation and contact the **Pediatric Care Management Department** at **1-855-772-8762 (TTY:711)** or outreach to **pediatriclead@upmc.edu.** Members with elevated blood levels are also appropriate for early intervention services. To arrange these services providers **must** contact **CONNECT** at **1-800-692-7288 (TTY: 711).** The referral to **CONNECT must** be documented in the medical records. Children with elevated lead levels should be managed according to CDC recommendations.

EPSDT Expanded Services

Expanded services are those services required to treat conditions a provider detects during an encounter with a Member who is **younger than 21 years old** that **may or may not** normally be covered by the Medical Assistance fee-for-service program (ACCESS) such as certain medical supplies or durable medical equipment.

All requests for EPSDT expanded services **must** be authorized by the **Utilization Management Department** by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers.** The request **must** include a letter of medical necessity describing the rationale for the expanded services and the benefit the service will provide the Member. Utilization Management will review the prior authorization request for medical necessity with the medical director. Urgent requests are processed **within 24 hours** to ensure that the child's medical care **is not** jeopardized.

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The Member and provider will be notified of the decision regarding the request for service **within 21 days** of the receipt of the request. This notice includes denials, reductions, or changes in scope or duration of services. If the decision to approve or deny a covered service or item is **not** made **by the 21st day** from the date the request was received, the service or item is automatically approved.

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

EPSDT Claims Submission and Payment

All PCPs **must** perform EPSDT screens according to the periodicity schedule.

➢ **See:** ***Appendix E.1, Other Resources and Forms, EPSDT Periodicity Schedule,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You* (Medical Assistance).

To receive reimbursement for an EPSDT screening, providers should submit their claims electronically or complete a CMS-1500 form utilizing the appropriate codes and modifiers, and send the claim **within 90 days of the date of service** to:

UPMC *for You*
PO Box 2995
Pittsburgh, PA 15230-2995

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Enhanced Member Supports Unit

The UPMC *for You* Enhanced Member Supports Unit (EMSU) is available to assist providers in connecting Members with special health care needs and/or other health related social needs to care management services and assist in troubleshooting care coordination needs as well as connecting to community-based resources to assist in addressing social barriers to accessing/managing/maintaining health.

Providers can contact the EMSU coordinators by email at **EMSUCoordinator@upmc.edu** or by calling **1-866-463-1462 (TTY: 711)** Monday through Friday from 8 a.m. to 6 p.m.

➢ **See:** ***Enhanced Member Supports Services,*** UPMC Health Plan Provider Manual, Chapter G, Utilization Management and Medical Management for additional information

School-Based and School-Linked Services

The EMSU coordinates school-based and school-linked services with providers to:

- Make sure PCPs interact with school-based centers as necessary.
- Arrange for the coordination and integration of school-based health service information into the PCP's Member record, as necessary.
- Help coordinate specialized treatment plans for children with special health care needs, including participation on interagency teams.

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Medical Assistance (MA) Provider Compliance Hotline

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

Recipient fraud is defined as someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits and that person is **not** reporting income, **not** reporting ownership of resources or property, **not** reporting who lives in the household, allowing another person to use their 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 when a provider bills for services, equipment, or **not** provided or bills for a different service than the service provided. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud, call the **UPMC *for You's* Fraud and Abuse Hotline** at **1-866-FRAUD-01(1-866-372-8301; TTY: 711).** The information may also be reported to the **DHS Fraud and Abuse Reporting Hotline** at 1**-844-DHS-TIPS (1-844-347-8477).**

Examples of provider fraud or abuse include: billing for services not provided; misrepresenting the service/supplies rendered (for example, billing brand named for generic drugs) billing for a different service than was rendered; billing for more time or units of service than provided; billing at a service location other than the service location at which services were provided; submitting false information on claims, such as date, provider, or prescriber of service; double billing for the same service; billing for services provided by unqualified persons; or billing for used items as new.

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

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

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

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Member Rights and Responsibilities

Member Rights

UPMC *for You* Members have the right:

- To be treated with respect, recognizing their dignity and need for privacy, by UPMC *for You* staff and in-network providers.
- To get information in a way that they can easily understand and find help when they need it.
- To get information that they can easily understand about UPMC *for You*, its services, and the doctors and other providers that treat them.
- To pick the in-network health care providers that they want to treat them.
- To get emergency services when they need them from any provider without UPMC *for You's* approval.
- To get information that they can easily understand and talk to their providers about their treatment options, without any interference from UPMC *for You*.
- To make all decisions about their health care, including the right to refuse treatment. If they **cannot** make treatment decisions by themselves, they have the right to have someone else help make decisions or make decisions for them.
- To talk with providers in confidence and to have their health care information and records kept confidential.
- To see and get a copy of their medical records and to ask for changes or corrections to their records.
- To ask for a second opinion.
- To file a Grievance if they disagree with UPMC *for You*'s decision that a service is **not** medically necessary.
- To file a Complaint if they are unhappy about the care or treatment they have received.
- To ask for a DHS Fair Hearing.
- To be free from any form of restraint or seclusion used to force them to do something, to discipline them, to make it easier for the provider, or to punish them.

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- To get information about services that UPMC *for You* or a provider does **not** cover because of moral or religious objections and about how to get those services.

- To exercise their rights without it negatively affecting the way DHS, UPMC *for You***,** and in-network providers treat them.

- To make recommendations about the rights and responsibilities of UPMC *for You*'s Members.

Member Responsibilities

Members need to work with their health care service providers. UPMC *for You* needs the Member's help so that they get the services and supports they need.

UPMC *for You* Members have the responsibility to:

- Provide, to the extent they can, information needed by their providers.

- Follow instructions and guidelines given by their providers.

- Be involved in decisions about their health care and treatment.

- Work with their providers to create and carry out their treatment plans.

- Tell their providers what they want and need.

- Learn about UPMC *for You* coverage, including all covered and non-covered benefits and limits.

- Use only in-network providers unless UPMC *for You* approves an out-of-network provider.

- Get a referral from their PCP to see a specialist.

- Respect other patients, provider staff, and provider workers.

- Make a good-faith effort to pay their copayments.

- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

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Member Complaint and Grievance Procedures

UPMC *for You* Members have a Complaint, Grievance, and Fair Hearing process available to them if they are unhappy about services provided by UPMC *for You* or their provider.

The UPMC *for You* Member Complaint, Grievance and Fair Hearing process is separate and distinct from the Provider Dispute process outlined in the UPMC Health Plan provider manual, Chapter B, Provider Standards and Procedures.

The Member may ask the provider to file a Complaint or Grievance on their behalf, but the Member, the Member's parent/guardian (responsible party), or the Member's designated representative **must** officially appoint the provider as their personal representative in writing.

Member's Written Consent Guidelines
If a Member requests that a provider file a grievance, the Member **must** complete a consent form or write a letter. The consent form or letter of consent **must** include certain information, statements, and signatures that are required by the Pennsylvania Department of Health.

Required Information
The following general information is required in the letter of consent or on the consent form:

- The name and address of the Member and of the policyholder (if they are different), the Member's date of birth, and the Member's identification number
- If the Member is a minor or is legally incompetent, the name and relationship to the Member of the person who signs the consent
- The name, address, and UPMC Health Plan's identification number of the provider to whom the Member is providing the consent
- UPMC Health Plan's name and address
- A description of the specific service for which coverage was provided or denied

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Required Statements
The following statements are required in the letter of consent or on a consent form:

- The Member or Member's representative may **not** submit a grievance concerning the services listed in this letter of consent or consent form unless the Member or Member's representative rescinds consent in writing. The Member or Member's representative has the right to rescind consent at any time during the grievance process.

- The consent of the Member or Member's representative shall be automatically rescinded if the provider fails to file a grievance.

- The Member or Member's representative has read this consent form and has had it explained to their satisfaction.

Required Signatures
The following signatures are required in the letter of consent or on a consent form:

- The dated signature of the Member or the Member's representative

- The dated signature of a witness

The following are instructions that have been provided to the Member in their UPMC *for You* Member handbook on how they may file a Complaint, Grievance, request a Fair Hearing, or an External Grievance review, and how to continue to receive services during the process.

➢ **Note:** The terms "**you**" or "**your**" in the following excerpt are referring to the Member.

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UPMC for You Member Handbook Excerpt
(Section 8 – Complaints, Grievances, and Fair Hearings)

Complaints, Grievances, and Fair Hearings

If a provider or UPMC *for You* does something that you are unhappy about or do **not** agree with, you can tell UPMC *for You* or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UPMC *for You* has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell UPMC *for You* that you are unhappy with UPMC *for You* or your provider or do **not** agree with a decision by UPMC *for You*.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You **cannot** get the service or item you want because it is **not** a covered service or item.
- You have **not** gotten services that UPMC *for You* has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First-Level Complaint

What Should I Do if I Have a Complaint?

To file a First-Level Complaint:

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Complaint, or
- Write down your Complaint and send it to UPMC *for You* using one of the below methods.
- If you received a notice from UPMC *for You* telling you UPMC *for You*'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to UPMC *for You* using one of the below methods.

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To file a First-Level Complaint	
UPMC *for You's* contact information for Complaints	
Mail	UPMC *for You* Complaints, Grievances, and Appeals PO Box 2939 Pittsburgh, PA 15230-2939
Fax	**412-454-7920**
Secure web portal	UPMC Health Plan Member site at **upmchealthplan.com** by logging in with your Member ID and password, and clicking "Forms and Guides" and "Plans and Coverage," then select "Complaint or Grievance Submission Form."
Secure email*	**upmcforyouappeals@upmc.edu**

- **Note:** *Because emails **are not** secure unless encrypted by the sender, you **should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

- **Note:** Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

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When Should I File a First-Level Complaint?

Some Complaints have a time limit on filing. You **must** file a Complaint **within 60 days of getting a notice** telling you that

- UPMC *for You* has decided that you **cannot** get a service or item you want because it is **not** a covered service or item.
- UPMC *for You* will **not** pay a provider for a service or item you got.
- UPMC *for You* did **not** tell you its decision about a Complaint or Grievance you told UPMC *for You* about **within 30 days** from when UPMC *for You* got your Complaint or Grievance.
- UPMC *for You* has denied your request to disagree with UPMC *for You*'s decision that you have to pay your provider.

You **must** file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below.

Table E.2: Appointment Standards

New Member appointment for your first examination…	We will make an appointment for you…
Members with HIV/AIDS	with PCP or specialist **no later than seven days** after you become a Member in UPMC *for You* unless you are already being treated by a PCP or specialist.
Members who receive Supplemental Security Income (SSI)	with PCP or specialist **no later than 45 days** after you become a Member in UPMC *for You*, unless you are already being treated by a PCP or specialist.
Members under the age of 21	with PCP for an EPSDT exam **no later than 45 days** after you become a Member in UPMC *for You***,** unless you are already being treated by a PCP or specialist.
All other Members	with PCP **no later than three weeks** after you become a in UPMC *for You*

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Members who are pregnant:	We will make an appointment for you . . .
Members in their first trimester	with ob-gyn provider **within 10 business days** of UPMC *for You* learning you are pregnant.
Members in their second trimester	with ob-gyn provider **within five business days** of UPMC *for You* learning you are pregnant.
Members in their third trimester	with ob-gyn provider **within four business days** of UPMC *for You* learning you are pregnant.
Members with high-risk pregnancies	with ob-gyn provider **within 24 hours** of UPMC *for You* learning you are pregnant

Appointment with…	An appointment must be scheduled . . .
PCP	
Urgent medical condition	**Within 24 hours**
Routine appointment	**Within 10 business days**
Health assessment/General physical examination	**Within three weeks**

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Specialists (when referred by PCP)	
Urgent medical condition	**Within 24 hours** of referral
Routine appointment with one of the following specialists: • Dentist • Dermatology • Orthopedic surgery • Otolaryngology • Pediatric allergy and immunology • Pediatric dentistry • Pediatric endocrinology • Pediatric gastroenterology • Pediatric general surgery • Pediatric hematology • Pediatric infectious disease • Pediatric nephrology • Pediatric neurology • Pediatric oncology • Pediatric pulmonology • Pediatric rehab medicine • Pediatric rheumatology • Pediatric urology	**Within 15 business days** of referral
Routine appointment with all other specialists	**Within 10 business days** of referral

➢ **Note: You may file all other Complaints at any time.**

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What Happens After I File a First-Level Complaint?

After you file your Complaint, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Complaint, and about the First-Level Complaint review process.

You may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint about **at no cost** to you. You may also send information that you have about your Complaint to UPMC *for You*.

You may attend the Complaint review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Complaint review **at least 10 days** before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do **not** want to attend the Complaint review, it will **not** affect the decision.

A committee of **one or more** UPMC *for You* staff who were **not** involved in and do **not** work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee. UPMC *for You* will mail you a notice **within 30 days** from the date UPMC *for You* received the complaint unless you have requested that UPMC *for You* take an **additional 14 days** from the date you filed your First Level to decide the Complaint. to the notice will tell you UPMC *for You's* decision on your First-Level Complaint and what you can do if you do **not** like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you file a Complaint that is postmarked, or received by UPMC *for You* **within 15 days** of the date on the notice telling you that the services or items you have been receiving are **not** covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like UPMC *for You*'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- UPMC *for You*'s decision that you **cannot** get a service or item you want because it is **not** a covered service or item
- UPMC *for You's* decision to not pay a provider not enrolled in the Medical Assistance Program for a service or item you got without authorization
- UPMC *for You*'s decision to **not** pay a provider for a service or item you got, because the service or item is not a covered service for you

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- UPMC *for You*'s failure to decide a Complaint or Grievance you told UPMC *for You* about **within 30 days** from when UPMC *for You* got your Complaint or Grievance

- You **not** getting a service or item within the time by which you should have received it

- UPMC *for You*'s decision to deny your request to disagree with UPMC *for You*'s decision that you have to pay your provider

You **must** ask for an external Complaint review by submitting your request in writing to the Pennsylvania Insurance Department's Bureau of Consumer Services **within 15 days of the date you got the First-Level Complaint decision notice.**

To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the **"File a Complaint Page"** at
insurance.pa.gov/Consumers/Pages/default.aspx.

If you need help filing your request for external review, call the **Bureau of Consumer Services** at **1-877-881-6388.**

You **must** ask for a Fair Hearing **within 120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second-Level Complaint **within 45 days of the date you got the Complaint decision notice.**

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Second-Level Complaint

What Should I Do if I Want to File a Second-Level Complaint?

To file a Second- Level Complaint:

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Second- Level Complaint, or
- Write down your Second-Level Complaint and send it to UPMC *for You* by, using one of the below methods, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to UPMC *for You*. using one of the below methods.

UPMC *for You's* contact information for Second-Level Complaints	
Mail	UPMC *for You* Complaints, Grievances, and Appeals PO Box 2939 Pittsburgh, PA 15230-2939
Fax	**412-454-7920**
Secure web portal	UPMC Health Plan Member site at **upmchealthplan.com** by logging in with your Member ID and password and clicking "Forms and Guides" and "Plans and Coverage," then select "Complaint or Grievance Submission Form."
Secure email*	**upmcforyouappeals@upmc.edu**

➢ **Note:** *Because emails are **not** secure unless encrypted by the sender, you **should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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What Happens After I File a Second-Level Complaint?

After you file your **Second -Level** Complaint, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Complaint, and about the Second-Level Complaint review process.

You may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint about **at no cost** to you. You may also send information that you have about your Complaint to UPMC *for You*.

You may attend the Complaint review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Complaint review **at least 15 days** before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference. If you decide that you do **not** want to attend the Complaint review, it will **not** affect the decision.

A committee of **three or more people**, including **at least one person** who does **not** work for UPMC *for You*, will meet to decide your Second-Level Complaint. The UPMC *for You* staff on the committee will **not** have been involved in and will **not** have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee.

UPMC *for You* will mail you a notice **within 45 days** from the date your Second-Level Complaint was received to tell you the decision on your Second-Level Complaint. The letter will also tell you what you can do if you do **not** like the decision.

What if I Do Not Like UPMC *for You*'s Decision on My Second-Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You **must** ask for an external review **within 15 days of the date you got the Second-Level Complaint decision notice.**

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External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209
Strawberry Square
Harrisburg, Pennsylvania 17120
Fax: 717-787-8585
Telephone Number: 1-877-881-6388

You can also go to the **"File a Complaint"** page at: **insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx.**

If you need help filing your request for external review, call the **Bureau of Consumer Services** at **1-877-881-6388.**

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Pennsylvania Insurance Department will get your file from UPMC *for You*. You may also send them any other information that may help with the external review of your Complaint. You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do **not** like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and your request for an external Compliant review is postmarked or received by the Pennsylvania Insurance Department **within 15 days** of the date on the notice telling you UPMC *for You's* First-Level Complaint decision that you cannot get service or items you have been receiving because they are **not** covered services or items for you, the services or items will continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing **within 15 days** of the date on the notice telling you UPMC *for You*'s First-Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services **will not** continue.

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GRIEVANCES

What is a Grievance?
When UPMC *for You* denies, decreases, or approves a service or item different than the service or item you requested because it is **not** medically necessary, you will get a notice telling you UPMC *for You*'s decision. A Grievance is when you tell UPMC *for You* that you disagree with UPMC *for You*'s decision.

What Should I Do if I Have a Grievance?
To file a Grievance:

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or
- Write down your Grievance and send it to UPMC *for You* by using one of the below methods or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from UPMC *for You* and send it to UPMC *for You* by using one of the below methods:

UPMC *for You's* contact information for Grievances	
Mail	UPMC *for You* Complaints, Grievances, and Appeals PO Box 2939 Pittsburgh, PA 15230-2939
Fax	**412-454-7920**
Secure web portal	UPMC Health Plan Member site at **upmchealthplan.com** by logging in with your Member ID and password and by clicking "Forms and Guides" and "Plans and Coverage," then select "Complaint or Grievance Submission Form".
Secure email*	**upmcforyouappeals@upmc.edu**

➢ **Note:** *Because emails are **not** secure unless encrypted by the sender, you **should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

➢ **Note:** Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you **cannot** file a separate Grievance on your own.

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When Should I File a Grievance?

You **must** file a Grievance **within 60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from UPMC *for You* telling you that UPMC *for You* has received your Grievance, and about the Grievance review process.

You may ask UPMC *for You* to see any information that UPMC *for You* used to make the decision you filed your Grievance about **at no cost** to you. You may also send information that you have about your Grievance to UPMC *for You*.

You may attend the Grievance review if you want to attend it. UPMC *for You* will tell you the location, date, and time of the Grievance review at least **10 days** before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference. If you decide that you do **not** want to attend the Grievance review, it will **not** affect the decision.

A committee of **three or more people**, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The UPMC *for You* staff on the committee will **not** have been involved in and will **not** have worked for someone who was involved in the issue you filed your Grievance about. UPMC *for You* will mail you a notice **within 30 days** from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do **not** like the decision.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance that is postmarked, or received by UPMC *for You* **within 15 days** of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

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What if I Do Not Like UPMC *for You*'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does **not** work for UPMC *for You*. You **must** ask for an external Grievance review **within 15 days** of the date you got the Grievance decision notice. You **must** ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or
- Write down your Grievance and send it to UPMC *for You* using one of the below methods:

UPMC *for You's* contact information for an External Grievances	
Mail	UPMC *for You* Complaints, Grievances, and Appeals PO Box 2939 Pittsburgh, PA 15230-2939
Fax	**412-454-7920**
Secure web portal	**UPMC Health Plan Member site** at **upmchealthplan.com** by logging in with your Member ID and password and clicking "Forms and Guides" and "Plans and Coverage," then selecting "Complaint or Grievance Submission Form."
Secure email*	**upmcforyouappeals@upmc.edu**

➢ **Note:** *Because emails **are not** secure unless encrypted by the sender, **you should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

UPMC *for You* will send your request for external Grievance review to the Pennsylvania Insurance Department.

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What Happens After I Ask for an External Grievance Review?

UPMC *for You* will notify you of the external Grievance reviewer's name, address, email address, fax number, and phone number. You will also be given information about the external Grievance review process.

UPMC *for You* will send your Grievance file to the reviewer, You may provide additional information that may help with the external review of your Grievance to the reviewer **within 20 days** of being notified of the external Grievance reviewer's name.

You will receive a decision letter **within 60 days** of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do **not** like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a written request that is postmarked or received by the Pennsylvania Insurance Department **within 15 days** of the date on the notice telling you UPMC *for You's* Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you **must** request both the external Grievance review and the Fair Hearing **within 15 days** of the date on the notice telling you UPMC *for You*'s Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will **not** continue.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **30 days** to get a decision about your First-Level Complaint or Grievance, or **45 days** to get a decision about your Second-Level Complaint, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly you **must** ask UPMC *for You* for an early decision.

To ask for an Expedited Complaint or Grievance

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and ask UPMC *for You* for an early decision or

- Write down your Complaint/Grievance and send it to UPMC *for You* using one of the below methods.

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- If you received a notice from UPMC *for You* telling you UPMC *for You*'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to UPMC *for You* using one of the below methods.

UPMC *for You's* contact information to request an Expedited Complaint or Grievance	
Mail	UPMC *for You* Complaints, Grievances, and Appeals PO Box 2939 Pittsburgh, PA 15230-2939
Fax	**412-454-7920**
Secure web portal	**UPMC Health Plan Member site** at **upmchealthplan.com** by logging in with your Member ID and password and clicking "Forms and Guides" and "Plans and Coverage," then select "Complaint or Grievance Submission Form".
Secure email*	**upmcforyouappeals@upmc.edu**

> ➢ **Note:** *Because emails are not secure unless encrypted by the sender, you **should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Your doctor or dentist should fax a signed letter to **412-454-7920 within 72 hours** of your request for an early decision that explains why UPMC *for You* taking **30 days** to tell you a decision about your First-Level Complaint or Grievance, or **45 days** to tell you the decision about your Complaint or Grievance, could harm your health.

If UPMC *for You* does **not** receive a letter from your doctor or dentist and the information provided does **not** show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, UPMC *for You* will decide your Complaint or Grievance in the usual time frame of **30 days** from when UPMC *for You* first got your First- Level Complaint or Grievance, or **45 days** from when UPMC *for You* first got your Complaint. or Grievance.

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Expedited Complaint and Expedited External Complaint

A committee of **one or more** people, including a licensed doctor or licensed dentist, will meet to review your Complaint. Other providers may participate in the review but, the licensed doctor or licensed dentist will decide your Complaint. The UPMC *for You* staff on the committee will not have been involved in and will **not** have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person but may have to appear by phone or by videoconference because UPMC *for You* has a short amount of time to decide an expedited Complaint. If you decide that you do **not** want to attend the Complaint review, it will **not** affect the decision.

UPMC *for You* will tell you the decision about your Complaint **within 48 hours** of when UPMC *for You* gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or **within 72 hours** from when UPMC *for You* gets your request for an early decision, whichever is sooner, unless you ask UPMC *for You* to take more time to decide your Complaint.

You can ask UPMC *for You* to take **up to 14 more days** to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for an expedited external Complaint review if you do **not** like the decision.

If you did **not** like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Pennsylvania Insurance Department **within two business days from the date you get the expedited Complaint decision notice.**

To ask for an expedited external review of a Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or go to

"File a Complaint Page" at
insurance.pa.gov/Consumers/Pages/default.aspx.
If you need help filing your request for external review, call the
Bureau of Consumer Services at **1-877-881-6388.**

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Expedited Grievance and Expedited External Grievance

A committee of **three or more people**, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The UPMC *for You* staff on the committee will **not** have been involved in and will **not** have worked for someone who was involved in the issue you filed your Grievance about. You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person but may have to appear by phone or by videoconference because UPMC *for You* has a short amount of time to decide the expedited Grievance. If you decide that you do **not** want to attend the Grievance review, it will **not** affect our decision.

UPMC *for You* will tell you the decision about your Grievance **within 48 hours** of when UPMC *for You* gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or **within 72 hours** from when UPMC *for You* gets your request for an early decision, whichever is sooner, unless you ask UPMC *for You* to take more time to decide your Grievance. You can ask UPMC *for You* to take **up to 14 more days** to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do **not** like the decision.

If you do **not** like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external review and an expedited Fair Hearing. You **must** ask for expedited external review **within two business days from the date you get the expedited Grievance decision notice.**

To ask for expedited external review of a Grievance:

- Call **UPMC *for You*** at **1-800-286-4242 (TTY: 711)** and tell UPMC *for You* your Grievance, or
- Send an email to UPMC *for You* at **upmcforyouappeals@upmc.edu,** or
- Write down your Grievance and send it to UPMC *for You* by mail or fax:

UPMC *for You*
Complaints and Grievances Department
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920

➢ **Note: *** Because emails are not secure unless encrypted by the sender, the Member **should not** include personal identifying information such as their date of birth or personal medical information unless the email is encrypted.

UPMC *for You* will send your request to the Pennsylvania Insurance Department **within 24 hours** after receiving it. You **must** ask for a Fair Hearing **within 120 days from the date on the notice** telling you the expedited Grievance decision.

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What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of UPMC *for You* will help you. This person can also represent you during the Complaint or Grievance process. You do **not** have to pay for the help of a staff member. This staff member will **not** have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer, or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell UPMC *for You*, in writing, the name of that person and how UPMC *for You* can reach them.

You or the person you choose to represent you may ask UPMC *for You* to see any information UPMC *for You* has about the issue you filed your Complaint or Grievance about **at no cost** to you.

You may call ***UPMC for You*** toll-free telephone number at **1-800-286-4242 (TTY: 711)** if you need help or have questions about Complaints and Grievances, you can contact your local **Pennsylvania Legal Aid Network** office at **1-800-322-7572** or call the **Pennsylvania Health Law Project** at **1-800-274-3258. (TTY: 1-866-236-6310).**

Persons Whose Primary Language Is Not English

If you ask for language services, UPMC *for You* will provide the services **at no cost** to you.

Persons with Disabilities

UPMC *for You* will provide persons with disabilities with the following help in presenting Complaints or Grievances **at no cost,** if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by UPMC *for You* at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

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DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases, you can ask the Department of Human Services to hold a hearing because you are unhappy about or do **not** agree with something UPMC *for You* did or did **not** do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after UPMC *for You* decides your First -Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing **must** be postmarked, faxed, or submitted by email* **within 120 days from the date on the notice** telling you UPMC *for You*'s decision on your First-Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is **not** a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- UPMC *for You*'s failure to decide a First-Level Complaint or Grievance you told UPMC *for You* about **within 30 days** from when UPMC *for You* got your Complaint or Grievance.
- The denial of your request to disagree with UPMC *for You*'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was **not** medically necessary
- **Not** getting a service or item within the time by which you should have received a service or item

You can also request a Fair Hearing **within 120 days** from the date on the notice telling you that UPMC *for You* failed to decide a First-Level Complaint or Grievance you told UPMC *for You* about **within 30 days** from when UPMC *for You* got your Complaint or Grievance.

> ➢ **Note:** * Because emails **are not secure unless** encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

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How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing **must** be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter or email.

If you write a letter or email*, it needs to include the following information:

- Your (the Member's) name and date of birth
- A telephone number where you can be reached during the day
- Whether you want to have the Fair Hearing in person or by telephone
- The reason(s) you are asking for a Fair Hearing
- A copy of any letter you received about the issue you are asking for a Fair Hearing about

You **must** send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
PO Box 2675
Harrisburg, PA 17105-2675
Fax 1-717-772-6328
Email: RA-PWCGFteam@pa.gov

➢ **Note:** *Because emails **are not secure unless** encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

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What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter **at least 10 days** before the date of the hearing.

You **may** come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer, or other person may help you during the Fair Hearing.

You **MUST** participate in the Fair Hearing. UPMC *for You* will also go to your Fair Hearing to explain why UPMC *for You* made the decision or explain what happened.

You **may** ask UPMC *for You* to give you any records, reports and other information about the issue you requested your Fair Hearing about **at no cost** to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided **within 90 days** from when you filed your Complaint or Grievance with UPMC *for You*, **not** including the number of days between the date on the written notice of UPMC *for You*'s First-Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because UPMC *for You* did **not** tell you its decision about a Complaint or Grievance you told UPMC *for You* about **within 30 days** from when UPMC *for You* got your Complaint or Grievance, your Fair Hearing will be decided **within 90 days** from when you filed your Complaint or Grievance with UPMC *for You*, **not** including the number of days between the date on the notice telling you that UPMC *for You* failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do **not** like the decision.

If your Fair Hearing is **not** decided **within 90 days** from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at **1-800-798-2339** to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for a Fair Hearing and your request is postmarked or received by the Department of Human Service **within 15 days** of the date on the notice telling you UPMC for *You's* First-Level Complaint or Grievance decision, the services or items will continue until a decision is made.

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Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing.

You can ask for an early decision by calling the **Department of Human Services** at **1-800-798-2339** by faxing a letter or the **Fair Hearing Request Form to 717-772-6328** or submitting a written request electronically by email* to: **RA-PWCGFHteam@pa.gov.**

Your doctor or dentist **must** fax a signed letter to **717-772-6328** explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does **not** send a letter, your doctor or dentist **must** testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision **within three business days** after you asked for a Fair Hearing.

If your doctor does **not** send a written statement and does **not** testify at the Fair Hearing, the Fair Hearing decision will **not** be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

> ➢ **Note:** *Because emails **are not** secure unless encrypted by the sender, you **should not** include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

You may call **UPMC *for You's*** toll-free telephone number at **1-800-286-4242 (TTY: 711)** if you need help or have questions about Fair Hearings, you can contact your local **Pennsylvania Legal Aid Network** office at 1 800-322-7572 or call the **Pennsylvania Health Law Project** at **1-800-274-3258 (TTY: 1-866-236-6310).**

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Appendix E.1
Other Resources and Forms

EPSDT Clinical and Operational Guidelines

upmchealthplan.com/providers/medical/resources/guidelines/epsdt-guidelines.aspx

Important information and forms:

- Adolescent Well-care and Telehealth Tip Sheet
- Autism Screening Tip Sheet
- CMS 1500 Form
- Day Calculator
- Dental Referral Form
- Developmental Screening: Provider Tip Sheet
- Early Intervention Referral Form
- EPSDT Billing Guide
- EPSDT Periodicity Schedule
- EPSDT Quarterly Report
- EPSDT Telemedicine Guide
- Immunization Schedules **(0-18 years and "catch-up")**
- Environmental Lead Investigative Request Form
- Lead Screening: Provider Tip Sheet
- Recommendations for Preventive Pediatric Oral Health Care (Dental Periodicity Schedule)
- Screening Tools:
    - Validated Screening Tools for Developmental Delays and Autism Spectrum Disorder
        - Developmental Screening Tools
        - Autism Screening Tools
    - Screening Tools for Maternal Depression
        - Depression Screening Tools
    - Tobacco, Alcohol, or Drug Use Assessment
        - Assessment Recommended by AAP
- Weight Assessment and Counseling Tip Sheet

➢ **Note:** This **is not** an exhaustive list of validated screening tools. UPMC Health Plan and UPMC *for You* **do not** endorse or require the use of any specific screening tool.

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Childhood Nutrition and Weight Management Services:

- Medical Assistance Bulletin: Childhood Nutrition and Weight Management Services for Recipients **Under 21 Years of Age**
- Provider Quick Tip: Childhood Nutrition and Weight Management Services Reminder

Telehealth Guidelines

upmchealthplan.com/providers/medical/resources/telehealth-guidelines.aspx

Provider Telehealth Toolkit

- Considering Telehealth
- Getting started
- Preparing your patients for telehealth
- Telehealth FAQ
- Quality measures and telehealth
- Policy/Billing and coding/reimbursement
- Well-child visit through telehealth
- Video visit checklist (clinical etiquette – from AMA)
- Cultural Sensitivity
- Overcoming barriers
- Becoming a telehealth provider in the UPMC Health Plan Provider Directory
- Home Health

Clinical Practice Guidelines:

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

- ADHD
- Adult Cholesterol Management
- Adult Diabetes
- Adult Preventative Guidelines
- Anxiety
- Asthma
- Cardiovascular Risk Factors and Coronary Artery Disease
- COPD
- Depression
- Heart Failure Guidelines
- Hypertension Management
- Lung Cancer Screening
- Opioid Use
- Pediatric Preventative Guidelines
- Prenatal Clinical Practice Guidelines
- Substance Abuse
- Additional Resources for UPMC Health Plan Members

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Medical Prior Authorization

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

- **Patient Health Guidelines**
  - Clinical Guidelines
  - Medical Record Documentation Guidelines
  - Preventive and Immunization Guidelines
  - Utilization Management Clinical Criteria

- **Physician Forms**
  - Autism Treatment Plan
  - Home Accessibility
  - Home Health
  - Long Term Services and Supports (LTSS) for CHC
  - MCO Shift Care Form
  - Nutritional Products
  - Obstetrical Needs Assessment
  - Out-of-Network Service Requests
  - Parenteral Nutrition
  - Provider Appeal on Behalf of a Member
  - Provider Consent Form to File a Fair Health on Behalf of a Member
  - Provider Consent Form to File a Grievance for a Member
  - Provider Consent Form to File a Grievance for a UPMC Community HealthChoices participant
  - Provider Dispute/Appeal Cover Sheet
  - Private Duty Nursing
    - Medical Necessity Form for Private Duty Nursing
    - Tip Sheet for Requesting Authorization of Shift Care Services
    - Concurrent Authorization Request Form
    - Agency Request Form to Transfer Shift Care Hours

- **Physician Certification Form for a Child with Special Needs**
  - Certification Form and Instruction
  - Letter Addressed to Physician from Department

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Appendix E.2- Copayment Schedule

Table E3: Copayment Schedule

Adult UPMC *for You* Members – age 18 and older*	
Service	**Copayment ***
Ambulance (per trip)	$0
Dental care	$0
Inpatient Hospital (Acute or Rehab)	
Per day	$3 max
Maximum with limits	$21 max
Medical Centers	
Convenience care or urgent care centers	$0
Emergency department (nonemergent visits)	$3 max
Emergency services	$0
Federally Qualified Health Center or Rural Health Center/Clinic	$0
Independent medical/surgical center	$3 max
Outpatient ambulatory surgical center	$3 max
Outpatient hospital short procedure unit	$3 max
Medical Equipment	
Purchase or rental	$0
Medical Visits	
Certified nurse practitioner	$0
Chiropractor	$2 max
Doctor (PCP, ob-gyn, specialist)	$0
Optometrist	$0
Podiatrist	$2 max
Therapy (occupational, physical, speech)	$2 max
Outpatient Hospital (includes Hospital-based Clinics)	
Per visit	$2 max
Outpatient Nonhospital Clinic	
Per visit	$0
Prescriptions	
Generic	$1 max
Brand	$3 max
Diagnostic Services (not performed in a doctor's office)	
Medical diagnostic testing (per service)	$1 max
Nuclear medicine (per service)	$1 max
Radiology diagnostic testing (per service)	$1 max
Radiation therapy (per service)	$1 max

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- **Note:** *A copayment is the amount that **some** members pay for **some** covered services.

- **Note:** *The following Members **do not** have to pay copayments:
  - Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
  - Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance
  - Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
  - Members who live in a personal care home or domiciliary care home
  - Members **younger than age 18**
  - Pregnant women, including the postpartum period **(12 months after the delivery)**

- **Note:** *The following services **do not** require a copayment:
  - Emergency services
  - Family planning services, including supplies
  - Home health services
  - Hospice services
  - Laboratory services
  - Tobacco cessation services

- **Note:** *Pharmacy copayments:
  If the Member is unable to pay the copayment they cannot be denied a prescription drug. The pharmacist can still try to collect the copayment.

  • For adults: Brand-name prescription drugs and brand-name over-the-counter drugs cost $3 for each new prescription or refill. Generic prescription drugs and generic over-the counter drugs cost $1 for each new prescription or refill.

  • For children: Brand-name prescription drugs and brand-name over-the-counter drugs cost $0 for each new prescription or refill. Generic prescription drugs and generic over-the-counter drugs cost $0 for each new prescription or refill.

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- Many categories of drugs **do not** have a copayment including the following:
  - Anticonvulsants (seizure drugs)
  - Antidepressants (drugs for depression)
  - Anti-diabetics (diabetes drugs)
  - Antiglaucoma agents (glaucoma drugs)
  - Antihypertensives (high blood pressure drugs)
  - Antineoplastics (cancer drugs)
  - Anti-Parkinson's agents (Parkinson's disease drugs)
  - Antipsychotics (drugs for psychosis)
  - Cardiovascular preparations (heart disease drugs)
  - Drugs for opioid overdose
  - Drugs, including immunization (shots), given by a physician
  - HIV/AIDS medications or agents
  - Family planning supplies

➢ **See:** The ***UPMC for You drug formulary and the Pennsylvania Medical Assistance Statewide PDL*** for a complete list of medications, specialty medicines, and plan exclusions at **upmchealthplan.com/providers/medical/resources/other/pharmacy.aspx.**

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Appendix E.3- Member ID Cards

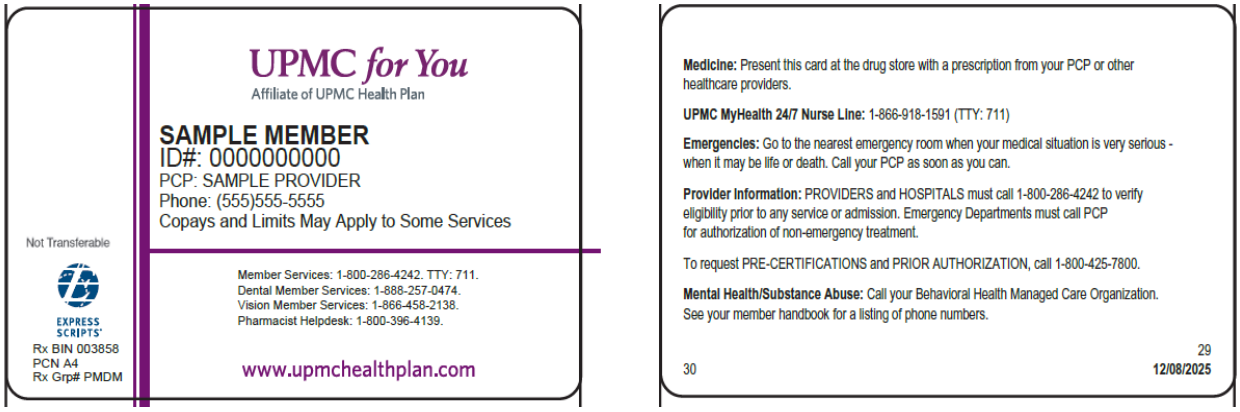
UPMC *for You* Members will receive a Member ID card, as will any other Members of their family who have enrolled in UPMC *for You*.

The UPMC *for You* Member ID card **does not** replace their ACCESS or EBT cards. It is important that the Member carries their UPMC *for You* Member ID card along with their DHS-issued ID cards (ACCESS card or EBT card) at all times. The Member will need to show the ID card(s) to receive the benefits and services that are covered by Medical Assistance. The UPMC *for You* Member ID card is valid as long as the individual is a UPMC *for You* Member

UPMC *for You* ID Cards **may contain some** of the following information.

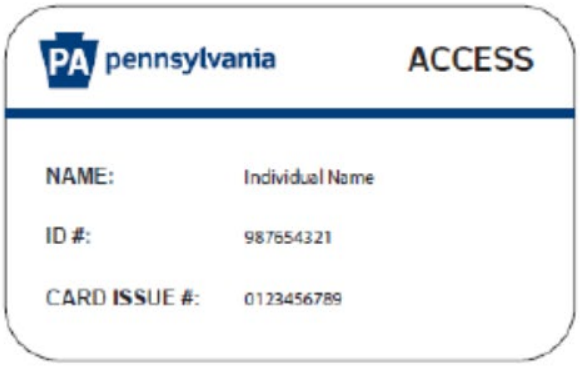
- Member Name
- Member Identification number
- Primary care provider (PCP)
- Primary care provider's telephone number
- Copays and Limits may apply to some services
- Telephone number of Member Services (the Member's Health Care Concierge team), Behavioral Health Services, 24/7 Nurse Line, and Pharmacy

Example #1: UPMC *for You* Member Identification Card



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Example #2: Department of Human Services Access and EBT cards









- **Note:** If a UPMC *for You* Member states that they lost their ACCESS or EBT card, they **must** contact the County Assistance Office (CAO) for a replacement. A list of CAO phone numbers can be found in the Member's Member handbook at **upmchealthplan.com.** The CAO information can also be found at: **pa.gov/agencies/dhs/contact/cao-information.**

- **Alert:** Member ID Cards Possession of a Member ID card does not guarantee a Member's eligibility. Providers **must** request any and all insurance cards from the Member before performing services. Providers should verify a Member's UPMC Health Plan eligibility by going to **upmchealthplan.com,** by calling the **Interactive Voice Response (IVR) system** at **1-866-406-8762,** or by calling **Provider Services** at **1-866-918-1595** Monday through Friday from 8 a.m. to 5 p.m.

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