Behavioral Health

This section of the UPMC Health Plan Provider Manual contains information pertinent to Behavioral Health Network Providers who are providing services to:

- UPMC Health Plan commercial members
- UPMC *for Life* members
- UPMC *for Kids* members

Please note UPMC Health Plan does not manage behavioral health benefits for Medical Assistance members and therefore the information contained in this section does not apply to behavioral health services provided to Medical Assistance members.

Information frequently changes, so please watch for *Provider Alerts* for the most up-to-date information for behavioral health network providers. *Provider Alerts* will be sent to you and will also be available on this website, www.ccbh.com. We welcome your suggestions about how UPMC Health Plan can improve our services to you as a network behavioral health provider. Together, we can present our members with a "seamless" system of high-quality behavioral health services and contribute positively to the communities and region in which we work.

The introductory pages below include a **Key Contact Page** and a **Summary Table of Behavioral Health Service Authorization Procedures**. Also, you will find more specific information regarding:

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

The Appendix contains a Glossary of Terms and Abbreviations especially prepared for behavioral health providers.

We look forward to working with you to provide high-quality, cost-effective behavioral health care to UPMC Health Plan members.

If you have any questions about material in this Behavioral Health Section of the Provider Manual, call the **Behavioral Health Provider Line at 1-888-251-2224, and press option 1.**

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Providing Behavioral Health Services to UPMC Health Plan Members

Key Contact Page for Behavioral Health Providers

Corporate Offices:

UPMC Health Plan
One Chatham Center, Suite 800
112 Washington Place
Pittsburgh, PA 15219

Community Care
(for Provider Contracting and Credentialing)
One Chatham Center, Suite 700
112 Washington Place
Pittsburgh, PA 15219

Provider Voice Line (24 hours a day, 7 days a week):
Telephone: 1-888-251-2224
At prompts, choose "Provider" (Press "1"), then "UPMC Health Plan" (Press "1")

Provider Fax Lines:

Authorization Forms	Fax: 1-888-249-5646
Other Clinical Information	Fax: 1-888-251-0087

Member Lines: All Member Services lines answer 24 hours a day, 7 days a week. Routine questions are best answered by calling during business hours, Monday through Friday from 8 a.m. to 5 p.m.

- Telephone: 1-888-251-0083; TTY: 1-877-877-3580
- Behavioral Health Case Management Programs: 1-888-777-8754
- Behavioral Health for UPMC *for Kids* (CHIP): 1-800-650-8762

UPMC Health Plan Claims Department: 1-888-876-2756

UPMC Health Plan Fraud and Abuse Hotline Number: 1-866-FRAUD-01

Provider Reference Materials:

- **Behavioral Health Provider Alerts, newsletter articles, and forms** can be found at www.upmchealthplan.com/providers/patient_index.html.
- The **Mental Health Medical Necessity Criteria Set** utilized by UPMC Health Plan Behavioral Health Services may be obtained as follows:
  - The Mihalik Group's Medical Necessity Manual for Behavioral Health, version

6.0.0, www.themihalikgroup.com. If you do not have a password or do not remember your password, call The Mihalik Group at 773-929-1722.

- The **Chemical Dependency Medical Necessity Criteria Sets** utilized by UPMC Health Plan Behavioral Health Services may be obtained as follows:
  - For Adults: Pennsylvania Client Placement Criteria, 2nd edition Department of Health, Bureau of Drug and Alcohol Programs, Room 929, Health and Welfare Building, Harrisburg, PA 17108.
  - For Children and Adolescents: American Society for Addiction Medicine (ASAM), Patient Placement Criteria (PPC-2R), ASAM Publications Distribution Center, P.O. Box 101, Annapolis Junction, MD 20701-0101; 1-800-844-8948; www.asam.org.

You may also contact UPMC Health Plan Behavioral Health Services at **1-888-251-2224** to obtain a copy of the Medical Necessity Criteria.

Table of Behavioral Health Service Authorization Procedures

The following Table of Behavioral Health Service Authorization Procedures outlines the procedures you need to follow to obtain authorization for services you propose to provide to UPMC Health Plan members. Obtaining authorization is essential (but not sufficient) for a claim for certain behavioral health services to be paid.

BEHAVIORAL HEALTH SERVICE AUTHORIZATION PROCEDURES

Service	Authorization Procedures
Inpatient Mental Health	• Requires precertification. For precertification, providers must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to the prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours/day, seven (7) days a week. • Medical necessity criteria as set forth in The Mihalik Group Medical Necessity Manual for Behavioral Health (Mihalik Manual) are used for decisions regarding precertification and continued stays. (See Adult Acute Inpatient Treatment, Adult 23-Hour Inpatient Observation, Child/Adolescent Acute Inpatient Treatment. and Child/Adolescent 23-Hour Inpatient Observation levels in the Mihalik Manual for in-depth criteria.)

	• Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Inpatient Detoxification	• Requires precertification. For precertification, providers must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to that prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven (7) days a week. • For adults, Pennsylvania's Client Placement Criteria (PCPC) are used for decisions regarding precertification and continued stays. (See PCPC Level 3A, Medically Monitored Inpatient Detoxification, and Level 4A, Medically Managed Inpatient Detoxification sections.) • For adolescents, American Society for Addiction Medicine (ASAM) Adolescent Patient Placement Criteria are used for decisions regarding precertification and continued stays. (See ASAM Level IV, Medically Managed Intensive Inpatient Services.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Inpatient Rehabilitation	• Requires precertification. For precertification, providers must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to that prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven (7) days a week. • For adults, PCPC are used for decisions regarding precertification and continued stays. (See PCPC Level 3B, Medically Monitored Short-Term Residential, and Level 4B, Medically Managed Inpatient Residential Sections.) • For adolescents, ASAM Adolescent Patient Placement Criteria are used for decisions about precertification and continued stays. (See ASAM Level III, Medically Monitored Intensive Inpatient Services.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Partial Hospitalization (Mental Health)	• Requires precertification. Provider must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to that prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven (7) days a week.

	• The Mihalik Group Medical Necessity Manual for Behavioral Health is used for decisions about precertification and continued stays. (See Adult Partial Hospital Treatment Mental Health and Child/Adolescent Partial Hospital Treatment Mental Health Sections in the Mihalik Manual.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Partial Hospitalization (Drug and Alcohol)	• Requires precertification. For precertification, provider must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to the prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven (7) days a week. • For adults, PCPC is used for decisions about precertification and continued stays. (See PCPC Level 2A Partial Hospitalization Section.) • For adolescents, ASAM Adolescent Patient Placement Criteria is used for decisions precertification and continued stays. (See ASAM Level II, Intensive Outpatient/Partial Hospitalization Services.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Intensive Outpatient (IOP) (Mental Health)	• Requires precertification. For precertification, providers must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to the prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven (7) days a week. • The Mihalik Group Medical Necessity Manual for Behavioral Health is used for decisions about precertification and continued stays. (See Adult Intensive Outpatient Treatment Mental Health and Child/Adolescent Intensive Outpatient Treatment Mental Health Sections in the Mihalik Manual.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Intensive Outpatient (IOP) (Drug and Alcohol)	• Requires precertification. For precertification, providers must call 1-888-251-2224 and press 1. Listen for prompt for UPMC Health Plan and press 1. After responding to the prompt, wait for the authorization prompt and press 1. Care managers are available to providers 24 hours a day, seven

	(7) days a week. • For adults, PCPC are used for decisions about precertification and continued stays. (See PCPC Level 1B Intensive Outpatient Section.) • For adolescents, ASAM Adolescent Patient Placement Criteria are used for decisions about precertification and continued stays. (See ASAM Level II, Intensive Outpatient/Partial Hospitalization Services.) • Continued stay reviews are completed on the last covered day authorized. • Facilities are required to call in for continued stay authorizations.
Outpatient Behavioral Health Services (Mental Health and Drug and Alcohol)	• Any in network claim submitted for outpatient mental health or substance abuse treatment will pay without an authorization provided that the member has unused outpatient benefits. • Psychological and neuropsychological testing with a psychiatric diagnosis will still require precertification and an authorization. • UPMC Health Plan Behavioral Health Services is available by phone to answer any questions you have related to behavioral health benefits, services, or claims.

Please note the following regarding behavioral health service authorizations:

- An authorization is not a guarantee of payment for services rendered.
- Members are to be held financially harmless if the provider fails to follow the proper authorization procedures. Members cannot be billed if the provider fails to obtain the proper authorization.
- Please remember to routinely check with members concerning any change in their insurance coverage. Members may change insurance plans and may neglect to inform the provider.
- Member benefits for each level of care vary according to the member's employer and/or the particular insurance plan that the member is enrolled in. Please discuss benefit limitations with the member or call our Behavioral Health Provider Line (1-888-251-2224) to verify benefits.
- It is important that providers tell us about any changes to their contact information or the services they provide so that members can be given accurate referral assistance.

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

- To verify that the services are covered
- To arrange for each member to receive the level of care he or she requires

- To provide member services in a seamless fashion
- To promote quality of behavioral health care

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

A. Verifying Member Eligibility for Behavioral Health Services Covered by UPMC Health Plan
B. Medical Necessity Criteria
C. Obtaining Authorizations (Precertification) and Other Utilization Review Activity
D. Provider Availability Standards
E. Standards for Member Access to Services (Waiting Time for Appointments)
F. Coordination of Care, Referrals, and Transition of Care to Other Providers
G. Referral Assistance Given to Members in Selecting Behavioral Health Providers
H. Statement regarding UPMC Health Plan Policy on Incentives
I. Clinical Practice Guidelines of Common Behavioral Health Disorders
J. UPMC Health Plan Pharmacy Formulary Information
K. Member Rights and Responsibilities

Verifying Member Eligibility for UPMC Health Plan Behavioral Health Benefits

Claims for behavioral health services are paid when a member is eligible to receive behavioral health services on the date he or she receives services from you (the provider). **Eligibility for services may change at any time**. Therefore, UPMC Health Plan strongly recommends that all providers verify with the member that he or she is still eligible for behavioral health services at each visit. You can additionally verify that an individual is eligible for behavioral health benefits by calling our **Provider Line** at **1-888-251-2224**.

Medical Necessity Criteria Sets Utilized by UPMC Health Plan

At the time of the member's initial visit to you, you will evaluate the member and determine what behavioral health services you believe the member needs. However, before you provide these services, you must make sure the services meet Medical Necessity Criteria for that level of care.

UPMC Health Plan Behavioral Health Services uses medical necessity criteria in determining whether to issue an authorization (preapproval, precertification) for certain types of behavioral health service outlined below.

If the patient's clinical condition necessitates a level of care that is covered in the patient's benefit plan but that level of care is not available, the next highest covered benefit level of care will be authorized.

The **mental health Medical Necessity criteria** currently being utilized by UPMC Health Plan Behavioral Health Services may be obtained as follows:

- *The Mihalik Group's Medical Necessity Manual for Behavioral Health, Version 5.2.3*, www.themihalikgroup.com. If you do not have a password or do not remember your password, please call The Mihalik Group at 773-929-1722.

The **chemical dependency Medical Necessity criteria sets** currently being utilized by UPMC Health Plan Behavioral Health Services may be obtained as follows:

- *Pennsylvania Client Placement Criteria, 2nd ed.*)**:** Department of Health, Bureau of Drug and Alcohol Programs, Room 929, Health and Welfare Building, Harrisburg, PA 17108. Note this set of criteria is utilized for **adult members**.
- *American Society for Addiction Medicine (ASAM), Patient Placement Criteria (PPC-2R).* ASAM Publications Distribution Center, P.O. Box 101, Annapolis Junction, MD 20701-0101, 1-800-844-8948, www.asam.org. Note this criteria set is utilized for children and adolescents.

You may also contact UPMC Health Plan Behavioral Health Services at **1-888-251-2224** to obtain a copy of the Medical Necessity criteria.

Obtaining Authorizations (Precertification) and Other Utilization Review Activity

Once you have determined that the services you intend to provide meet medical necessity (level of care) criteria, you can be paid for the service only if UPMC Health Plan agrees with the determination and has given you authorization to provide certain types of behavioral health services. Authorization is an agreement between you and UPMC Health Plan that the care you plan to provide to a specific member meets the applicable medical necessity criteria.

Providers must obtain precertification/preapproval before providing the following behavioral health services to UPMC Health Plan members:

Mental Health Services

- Psychological and Neuropsychological Testing
- Electroconvulsive Therapy
- Intensive Outpatient Program
- Partial Hospitalization Program
- Inpatient Admission

Chemical Dependency Services

- Intensive Outpatient Program
- Partial Hospitalization Program

- Medically Managed Rehabilitation (hospital-based)
- Medically Monitored Rehabilitation (short-term, non-hospital)
- Medically Managed Detoxification (hospital-based)
- Medically Monitored Detoxification (non-hospital)

To obtain **precertification/preapproval authorization** for these services for a UPMC Health Plan member, call our **Provider Line 1-888-251-2224,** 24 hours a day, seven (7) days a week to review medical necessity criteria with a care manager. An authorization number will be generated for a certain time frame and number of units of service. You will be given the number at the time of precertification/preapproval and will also be sent an authorization report.

The Summary Table of **Behavioral Health Service Authorization Procedures** listed on pages 4−5 indicates whether **precertification or prior authorization** is required for certain behavioral health service and outlines the steps you should follow to obtain precertification.

Important Notes:

- Receiving authorization is not a guarantee that the claim will be paid (other criteria must be met).
- Many benefit packages have session limits. Benefit package limits apply to the **member**, not to the provider. For example, a benefit limit of 20 visits/benefit year means that the **member** has a maximum of 20 available visits, for both psychotherapy and medication visits with a psychiatrist, per benefit year - **not** 20 visits for each separate provider.
- For certain services requiring precertification, additional information must be submitted to UPMC Health Plan Behavioral Health Services staff before an authorization is given. The specific process and documentation requirements will be explained during the precertification call with the UPMC Health Plan care manager.

Other Utilization Review Activity

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

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

- Inpatient services
- Rehabilitation services
- Partial hospitalization program services
- Intensive outpatient services
- Requests for out-of-network services

Care management staff are not compensated financially, nor is their job performance rated, based upon the number of denials or limits on benefits authorized.

UPMC Health Plan's utilization management decision making is based only on appropriateness of care and service and existence of coverage. UPMC Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or service care and does not offer financial incentives for utilization management decision makers.

Care Managers May Not Deny Care

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

Reviews by Peer Advisors

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

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

Other Clinical Reviews

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

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

Provider Availability Standards

UPMC Health Plan has established provider availability standards (i.e., geographic access standards and ratios of members to providers) for its affiliated behavioral health network. The goals are as follows:

- 30 minutes (urban) and 60 minutes (rural) driving time to all behavioral health specialty types. Note thirty minutes is equal to 20 miles and 60 minutes is equal to 45 miles.
- Ratio of members to psychiatrists: 2,000:1
- Ratio of members to psychologists: 1,500:1
- Ratio of members to master's-level therapists: 1,500:1
- Ratio of members to child and adolescent therapists: 750:1
- Ratio of members to partial hospital programs for mental health: 10,000:1
- Ratio of members to inpatient mental health facilities: 12,000:1
- Ratio of member to inpatient substance abuse facilities: 20,000:1
- Ratio of members to partial hospital programs for mental health: 10,000:1
- Ratio of members to partial hospital programs for substance abuse: 10,000:1

UPMC Health Plan monitors performance regarding provider availability standards at least annually.

Standards for Member Access to Services (Waiting Times for Appointments)

UPMC Health Plan standards require that members be given access to covered services in a timely manner, depending on the urgency of the need for services, as follows:

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

UPMC Health Plan monitors access to behavioral health services on at least an annual basis and intervenes as necessary.

Behavioral Health Emergencies

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

- A life-threatening behavioral health emergency occurs when as a result of a mental illness or substance use disorder, there is reason to believe the member is, or may become, homicidal or suicidal or the member or member's victim may suffer a disabling

or permanent physical injury as a result of the member's behavior or condition. The assessment that a life-threatening emergency exists is based upon statements or behavior, member self-report, information obtained objectively, or clinical judgment. **Care is required immediately for life-threatening emergencies.**

- A non-life-threatening behavioral health emergency occurs when as a result of a mental illness or substance abuse disorder, the member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within one hour. **Care is required within one (1) hour for non-life-threatening emergencies.**

Emergency services do not need precertification (preapproval) by UPMC Health Plan. It is expected that the emergency room, mobile crisis service, or outpatient provider will take immediate action for the safety of the member and others and will contact UPMC Health Plan for service authorization as soon as the situation is stabilized.

If UPMC Health Plan is contacted regarding a member's need for an emergency service, UPMC Health Plan care managers will provide a referral to an emergency provider, help arrange emergency transportation, and assist with other necessary arrangements to make emergency services available immediately or within one (1) hour of the contact. UPMC Health Plan staff may follow up with the provider to ascertain compliance with this standard for access to emergency behavioral health services.

Urgent Behavioral Health Conditions

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

- As a result of a mental illness or substance use disorder, a member is experiencing signs, symptoms, or impairment in functioning that would likely require an intensive level of care within 24 hours if treatment is not provided; **OR**

- A member expresses a readiness for, or amenability to, treatment if initiated within a 24-hour period.

Access to care for urgent behavioral health conditions must be provided within 24 hours.

Routine Outpatient Services

A **routine** outpatient service exists if the member exhibits signs or symptoms of a mental illness or substance use disorder that indicate the need for assessment and/or treatment without evidence

of imminent or impending risk to the member or others, or of an acute, significant change in level of functioning.

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

Access to routine services must be provided within seven (7) days.

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

If the member prefers an alternative appointment time that falls beyond the prescribed time frame, the provider should document this in the provider's appointment records.

As part of UPMC Health Plan's outreach efforts, UPMC Health Plan staff may contact a provider or a member to make arrangements for certain appointments, such as follow-up appointments after inpatient care, to be kept.

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

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

UPMC Health Plan's Expectations for Exchange of Information with Primary Care Physicians and Other Behavioral Health Providers to Facilitate Continuity and Coordination of Care: Coordination of Care with the member's primary care physician (PCP) or other behavioral health provider is always expected and particularly important when the member is prescribed a medication or treatment that may have an impact on the member's health or interact with medication or treatment prescribed by the PCP or psychiatrist.

Members for whom coordination of care is especially important include:

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

To promote needed communication with the PCP or other behavioral health provider, UPMC

Health Plan requires that provider tell each member about the importance of involving his or her PCP or other behavioral health provider in the behavioral health plan of care. UPMC Health Plan also expects that you will follow up with the PCP or other behavioral health provider. Please obtain the member's written authorization and communicate pertinent information as needed.

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

Referrals to Other Behavioral Health Network Providers is appropriate when you determine that a UPMC Health Plan member requires behavioral health services that are not within the scope of your practice. In these instances, you can call the **Provider Line** at **1-888-251-2224** and ask an intake coordinator for help in identifying network providers who can provide those services.

Except in an emergency, a health maintenance organization (HMO) member may not be referred to a provider outside the UPMC Health Plan affiliated network without prior authorization from UPMC Health Plan.

Members with a Point of Service (POS) or a Preferred Provider Organization (PPO) insurance plan may see out-of- network providers and may incur higher out-of-pocket expenses.

Transition of Care to Another Network Behavioral Health Provider may be necessary when a behavioral health provider is no longer participating in the network(s) affiliated with UPMC Health Plan. When a behavioral health provider contract is voluntarily terminated, a transition period of up to 90 days may be allowed for members under the terminated provider's care if the member was actively involved in treatment at the time of the termination.

Referral Assistance Given to Members in Selecting Behavioral Health Providers

UPMC Health Plan Member Services representatives assist members who ask for help in identifying a behavioral health provider who will meet their needs. Members may request help in identifying potential providers who meet certain selection criteria such as provider location and specialty type. To provide a selection of providers, the Member Services representative consults a database which contains the most current information providers have supplied to Credentialing, Provider Relations, and/or Network Department staff. Member Services representatives may disclose the following information about prospective providers to help the member select potential providers:

1. Name
2. Specialty
3. Office location, telephone number, and office hours
4. Gender (based on credentialing/recredentialing forms completed by the provider)
5. Professional credentials, including board certification if applicable
6. Hospital and/or practice group affiliation
7. Languages spoken by provider/provider staff (based upon the information providers disclose on credentialing/recredentialing or assessment/reassessment application forms)
8. Capacity to accept new patients

Member Services representatives may **not** disclose providers' malpractice limits and/or history, National Practitioner Data Base information, or Drug Enforcement Agency (DEA) number. Member Services representatives will not refer members to a provider who is not currently accepting new patients nor indicate a preference of one provider over another. If the member requires additional assistance in selecting a provider, the call will be referred to a care manager. **Members may ask to change their behavioral health provider at any time.**

Statement of UPMC Health Plan's Policy on Incentives

Utilization management decisions at UPMC Health Plan are based on the appropriateness of care and service for eligible members and existence of coverage. Practitioners or other individuals involved in utilization management are not specifically rewarded for issuing denials for coverage of care. UPMC Health Plan does not offer financial incentives for utilization management decision-makers at any level of the organization that encourage conflicts of interest or decisions that could lead to incidents of underutilization.

Clinical Practice Guidelines for Common Behavioral Health Disorders

UPMC Health Plan utilizes clinical practice guidelines to help behavioral health practitioners and members make decisions about appropriate health care for specific clinical circumstances. These evidence-based guidelines are reviewed annually, updated as appropriate, and approved by UPMC Health Plan's Quality Improvement Committee. Annually, UPMC Health Plan measures providers' performance against each of the clinical practice guidelines via claims data or medical record reviews. Providers may be notified of the results of these measurements via provider newsletters or Web-based communications. Information regarding the most current guidelines adopted by UPMC Health Plan can be found at http://www.upmchealthplan.com/online/providers_cg.html.

For information about our practice guideline adherence measurements, contact UPMC Health Plan at 1-866-918-1595 and ask to speak to a Quality Improvement staff member.

UPMC Health Plan Pharmacy Formulary Information

For the most current information about UPMC Health Plan pharmacy formulary and related resources, please refer to the UPMC Health Plan website at http://www.upmchealthplan.com. Click on the link, For Providers, and then select the Pharmacy link.

Member Rights and Responsibilities

All members of UPMC Health Plan have certain rights and responsibilities. Every staff person and behavioral health provider has the obligation and responsibility to know these rights and responsibilities and to support them in daily operations.

Member responsibilities are intended to serve as guidelines to help the member, provider, and others work cooperatively and effectively for the member's benefit.

http://www.upmchealthplan.com/about/overview/pdf/Mbr%20RR_COM.pdf

http://www.upmchealthplan.com/about/overview/pdf/Mbr%20RR_MC.pdf

http://www.upmchealthplan.com/about/overview/pdf/Mbr%20RR_CHIP.pdf

About Being a Network Behavioral Health Provider

Behavioral health providers are encouraged to telephone the **Behavioral Health Provider Line** at **1-888-251-2224** (24 hours a day, seven (7) days a week) for any assistance needed.

Community Care, UPMC Health Plan's affiliate, is responsible for contracting and credentialing behavioral health providers for inclusion into the network(s) associated with UPMC Health Plan. Community Care contracts with the following types of behavioral health providers (to provide behavioral health services to UPMC Health Plan Commercial, UPMC *for Life*, and UPMC *for Kids* members):

- **Practitioners** in individual or group practice, including:
  - psychiatrists
  - addictionologists
  - developmental-behavioral pediatricians
  - doctoral or master's-level licensed clinical psychologists
  - doctoral or master's-level clinical psychiatric nurse specialists
  - doctoral or master's-level certified registered nurse practitioners
  - doctoral or master's-level licensed social workers
  - and other master's or doctoral level licensed behavioral health clinicians)
- **Facilities** (facilities and organizations)
- **Providers** (denotes information that applies to both practitioners and facilities)

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

A. Practitioner Credentialing, Contracting, & Recredentialing
B. Facility/Organization Assessment, Contracting, and Reassessment
C. Record Keeping Standards
D. Adverse Event Reporting (to Protect Patient Safety)
E. Provider Cultural Competency
F. Provider Benchmarking
G. Provider Satisfaction
H. Provider Disputes Regarding Adverse Medical Necessity Determinations
I. Provider Education
J. Provider Advisory Committee
K. New Technologies
L. Availability of Behavioral Health Case Management Programs
M. Confidentiality and Disclosure Policies

Practitioner Credentialing, Contracting, and Recredentialing

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

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

Behavioral health practitioners must be recredentialed every two (2) years.

Practitioner Credentialing Process

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

- Eligibility criteria are met without exception.
- All requested information is present
- No discrepancies exist in the information provided by the practitioner and the information received from verification sources.

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

The practitioner credentialing process involves four major steps:

- Each credential (degrees, certifications, licenses) must be verified with primary sources (academic institution, certifying body, licensing board, or agency, etc.).
- Community Care conducts office site visits to the offices of all potential high-volume practitioners.
- Each location where a potential high-volume practitioner will offer behavioral health services to UPMC Health Plan members must "pass" a site visit. If, after credentialing, a practitioner adds a location where behavioral health services are to be provided and the new location has not had a site visit, a site visit will need to be conducted at this new location.
- Record keeping must "pass" a review of treatment record keeping practices, which may include review of a blinded treatment record or a treatment record mock-up. The site visit

includes review of treatment record keeping practices, including such items as assessment of secure/confidential filing systems, legibility of file markers, and ease of record location. If a practitioner is joining an existing group practice that had a site visit prior to the Credentialing Committee decision date and the site visit is not more than two (2) years old, another site visit is not needed. If a practitioner is joining an existing group practice that had a site visit prior to the credentialing decision date and the site visit is more than two (2) years old, another site visit is needed.

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

Verifying credentials with primary sources is performed by Community Care's Credentialing Department.

Trained professionals employed by Community Care conduct the site visit. Before the site visit is scheduled, the practitioner will be given a copy of the Potential High-Volume Practitioner On-Site Review Form and Medical Record Review Form. The Potential High-Volume Practitioner On-Site Review Form lists the criteria for credentialing/recredentialing a site, such as presence of fire extinguishers, handicapped-accessible restroom, policies and procedures in place for providing emergency care, and policy or policy statement regarding cultural awareness and diversity competence.

Included in the site visit is the review of record keeping practices Medical Record Review Form, which is performed to assess the adequacy of record keeping practices.

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

Practitioners have the following rights during the credentialing process:

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

Any of the rights above can be initiated verbally or in writing by contacting the Community Care Credentialing supervisor:

Community Care Credentialing Department
One Chatham Center, Suite 700
112 Washington Place
Pittsburgh, PA 15219

Change in Practitioner Information

Any change to information submitted by a behavioral health practitioner during the credentialing and contracting process or at any time thereafter, including information such as street and suite address and telephone and facsimile numbers, must be communicated to Community Care's Provider Relations Department. To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to UPMC Health Plan Members, practitioners are asked to call the Provider Line (1-888-251-2224) with any change to practitioner information. Community Care will send a Practitioner Change of Information Form to be completed and returned so that all departments can be notified of the change.

PLEASE NOTE: If a practitioner change involves **adding** or **changing** a contract service or a site where services are provided to UPMC Health Plan members, the addition or change must meet recredentialing standards and a site visit may be required — **before** payment for services can be processed.

Practitioner Contracting

A behavioral health practitioner may begin the contracting process after the practitioner completes credentialing by Community Care. Community Care seeks to contract with specific practitioners to provide specific behavioral health services at specific sites. (See the Table of Behavioral Health Service Authorization Procedures on pages 4-5 of this Provider Manual for listing of behavioral health services.) Criteria considered for contracting include:

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

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

When necessary to meet anticipated or actual member needs or payer requirements, Community Care's Network Development staff will work with the Credentialing and UPMC Health Plan Behavioral Health Services Departments to identify specialized services.

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

Practitioner Recredentialing

Behavioral health practitioners must be **recredentialed** two (2) years from the date of initial credentialing or last recredentialing date. The Community Care Credentialing Department will notify behavioral health practitioners in advance when it is time to start the recredentialing process. The recredentialing process is similar to the credentialing process with the additional consideration of quality information supplied by the Quality Improvement Department. An application for recredentialing is considered complete when it includes the following:

- Primary source verification of the practitioner's credentials (any new degrees or certifications, etc., since the time of the last credentialing or recredentialing date, verification of current licensures, malpractice, and claims history, etc.)
- Practitioner performance monitoring, including analyses of member complaints, Adverse Event reports, provider benchmarking issues, and Quality and/or Compliance audit results.

All practitioners must be recredentialed before their expiration date. Failure to be recredentialed before the expiration date will result in termination of the practitioner's contract with Community Care and will prevent payment for any services provided after the expiration date.

A behavioral health practitioner whose credentials with Community Care have expired cannot be authorized or paid for services provided after the expiration date. Because verifying credentials with primary sources requires **a minimum** of **seven** (**7**) **weeks** and may take up to **six** (**6**) **months**, Community Care's Credentialing Department sends applications for recredentialing before each practitioner's deadline. Practitioners are urged to start the recredentialing process as soon as the application is received. The Credentialing Department will remind practitioners periodically of application components that remain incomplete.

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

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

Any of the rights above can be initiated verbally or in writing by contacting the Credentialing supervisor:

Community Care Credentialing Department:
One Chatham Center, Suite 700
112 Washington Place
Pittsburgh, PA 15219

Facility/Organization Assessment, Contracting, and Reassessment

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

A facility must be reassessed every three (3) years.

Facility/Organization Assessment

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

The facility assessment process involves four major steps:

- Credentialing staff confirms the facility's licensure and facility's accreditation, if any, and status or standing of the facility with state regulatory bodies
- In lieu of Community Care doing a site visit, Community Care will accept the facility's CMS or state review report and any corrective action related to the review
- Each location where the facility will offer behavioral health services to UPMC Health Plan members must "pass" a site visit unless the facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA). If, after assessment, a facility adds a location where behavioral health services are to be provided and the new location has not been reviewed, a site visit will need to be conducted on this new location.
- Documentation must "pass" the review of treatment record keeping practices, which may include review of a blinded or mock-up treatment record. The site visit includes a review of treatment record keeping practices.
- The completed application (with all primary source verification completed, site visit(s), and treatment record keeping practices completed satisfactorily) must be reviewed and approved **within 180 days of the date the application was signed**. To verify that data accurately reflects current facility information, Community Care maintains the 180-day standard to complete this process. In the event that this process **exceeds 180 days**, the facility will be sent a copy of the original application and will be required to sign a new attestation to confirm that the data is currently accurate or will need to revise the information on the original application.

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

Included in the site visit is the review of treatment record keeping practices using the Medical Record Review Form, which is performed to assess the adequacy of documentation/record keeping procedures.

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

Facilities have the following rights during the assessment process:

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

Any of the rights above can be initiated verbally or in writing by contacting the Credentialing supervisor:

Community Care Credentialing Department
One Chatham Center, Suite 700
112 Washington Place
Pittsburgh, PA 15219

Change in Facility Information

Any change to information submitted by the facility during the assessment and contracting process or any time thereafter, including information such as mailing address and telephone and facsimile numbers, must be communicated to Community Care's Provider Relations Department. To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to UPMC Health Plan members, facilities are asked to call the Behavioral Health Provider Line (**1-888-251-2224**) with **any** change to Facility information. If necessary, Community Care will send a Facility Change of Information Form to be completed and returned so that all departments can be notified of the change.

*PLEASE NOTE: If the facility change involves **adding** or **changing** a service or a site where services are provided to UPMC Health Plan members, the addition or change must be reviewed and a site visit may be required **before** payment for services can be processed.*

Facility Contracting

A facility may begin the contracting process after the facility completes assessment by Community Care. Community Care seeks to contract with facilities to provide specific behavioral health services in specific geographic locations. (See the Table of Behavioral Health Service Authorization Procedures on pages 4-5 of this section of the UPMC Health Plan Provider Manual.) Criteria considered for contracting include:

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

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

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

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

Facility Reassessment

Facilities must be reassessed three (3) years from the date of initial assessment and or of the last reassessment.

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

- Credentialing staff confirms any new licensures, facility accreditation, and certifications, etc., since the date of the last assessment/reassessment, verification of current licensures, etc.
- Monitors of facility performance, including analyses of member complaints, Adverse Events reports, and Quality and/or Compliance audit results.

All facilities must be reassessed before their expiration date. Failure to be reassessed before the expiration date will result in termination of the facility's contract with Community Care and will prevent payment for any services provided after the expiration date.

A facility whose assessment with Community Care has expired cannot be authorized or paid for services provided after the expiration date. Because verifying credentials with primary sources

requires **a minimum** of **seven** (**7**) **weeks** and may take up to **6 months**, Community Care's Credentialing Department sends applications for reassessment before each facility's deadline. Facilities are urged to start the reassessment process as soon as the application is received. The Credentialing Department will remind facilities periodically of application components that remain incomplete.

Facilities have the following rights during the reassessment process:

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

Any of the rights above can be initiated verbally or in writing by contacting the Credentialing supervisor:

Ms. Janet Arrigo
Credentialing Supervisor
Community Care Behavioral Health Organization
One Chatham Center, Suite 700
Pittsburgh, PA 15219
412-454-2120

Termination of Provider from the Behavioral Health Network

A provider may be terminated from the Behavioral Health Network without cause or with cause.

Termination Without Cause

After the initial one (1) year term, the Provider Agreement may be terminated without cause by either party at any time upon **ninety** (**90**) **days**' prior written notice to the other party. Such notice shall clearly state the effective date of termination. All terms and provisions of this agreement shall remain in effect until the effective date of termination except as otherwise noted.

Termination with Cause

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

- Material breach of the provider agreement
- Loss or suspension of accreditation, if required
- Loss of required insurance
- Failure by the provider to abide by all the terms and conditions of the applicable Quality Improvement and UPMC Health Plan Behavioral Health Services programs as determined by Community Care in its sole discretion

- Provider is adjudged bankrupt, becomes insolvent, has a receiver of assets or property appointed, makes a general assignment for the benefits of creditors, or institutes or causes to be instituted any procedure for reorganization or rearrangement of his/her/its affairs
- If applicable, the provider's medical staff privileges at any provider are suspended, revoked, terminated, or voluntarily relinquished in lieu of disciplinary action

The provider is notified in writing via certified mail of the action to initiate termination with cause, including the reason for this action. Included in this correspondence is an explanation of the process to request an appeal of the decision to terminate with cause. (See following **Section II**.**B6.**)

Immediate Termination by Community Care

Action to terminate a Behavioral Health Provider immediately with cause may be initiated when Community Care becomes aware of any of the following:

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

Notification and Process to Appeal Adverse Determinations Regarding Network Participation

Behavioral health providers are notified in writing of any determination affecting their continued participation in the Behavioral Health Provider Network, including credentialing/recredentialing or assessment/reassessment, suspension of new referrals, or termination from the network. This written notification will include the reason for the decision and an explanation of the appeal process, if any. Immediate Termination by Community Care as described in Section II.B5c above is not subject to appeal.

The appeal process, if applicable, is as follows:

1. Within **30 days** from the date of the notification, the provider must send a letter, fax, or e-mail to the Community Care chief medical officer (CMO) to request to appeal the decision.
2. The CMO will schedule an Appeal Committee meeting to be held within **30 days** of receiving the provider's request.
3. The provider will be informed of the date, time, and place of the meeting and of the provider's right to be present at the hearing, to be represented by an attorney, to present relevant information, and to request a different date and time of hearing should the provider be unable to attend the hearing as scheduled.
4. UPMC Health Plan will be informed of the provider's request to appeal the action and the right of UPMC Health Plan to be present at the hearing, to be represented by an attorney, to present relevant information, and to request a different date and time of hearing should UPMC Health Plan be unable to attend the hearing as scheduled.
5. The provider will receive written notification of the Appeal Committee's decision within **two (2) business days** of the date of the decision.

The decision of the Appeal Committee is final.

Record Keeping Standards

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

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

- The patient address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, authorization forms, and guardianship information are documented, as relevant.
- The patient's name or identification number is present on each page.
- The responsible clinician's name and professional degree are documented.
- All entries are dated.
- The record is legible.
- Relevant medical conditions are listed, prominently identified, and updated.
- Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- Special status situations such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented, and updated in compliance with written protocols.

- Past medical and psychiatric history is documented, including previous treatment dates, provider information, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
- Allergies and adverse reactions are clearly documented.
- Assessment for co-occurring disorders is documented.
- Documentation of continuity and coordination of care efforts between behavioral practitioners and the PCP as well as with other behavioral health providers.
- Medication(s) that have been prescribed, dosages of each medication, and the dates of initial prescription and of any changes in medication regimen, if applicable.
- DSM-IV TR diagnosis on all five axes (I, II, III, IV, and V) is documented.
- Complete developmental history is documented for children and adolescents.
- The following are documented:
  - Symptoms
  - Mental status at each session
  - Patient strengths and limitations
  - Compliance with treatment plan
  - Compliance with medication regimen, if appropriate
  - Progress towards treatment goals
  - Coordination of care information, as applicable
  - Date of next session
  - Discharge plan

Community Care and UPMC Health Plan expect providers to maintain an organized treatment record keeping system. The following elements are required components of an organized record keeping system:

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

Community Care and UPMC Health Plan expect all practitioners and facilities to provide treatment to members in a safe environment. All providers should assess a member for suicidal ideation and homicidal ideation throughout a member's treatment. If a member is being treated in an outpatient setting and expresses suicidal or homicidal ideation, the provider should take the appropriate actions to safeguard the member and/or others, such as facilitating an inpatient hospital admission.

Upon admission for an inpatient psychiatric hospitalization, the Initial Evaluation completed by the facility psychiatrist should clearly document that the member was assessed for both suicidal

and homicidal ideation. Members being treated in an inpatient setting should be assessed for suicidal and homicidal ideation on an ongoing basis to ensure the member's safety, as well as the safety of others. Providers should also proceed with a Duty to Warn, if indicated.

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

All medical records and reports completed by the provider for UPMC Health Plan members are to be available, as appropriate, to other practitioners treating the member, Community Care, UPMC Health Plan, the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), State Department of Health, licensing body, or regulatory agency, or other agencies as required by applicable law and regulations, for at least seven (7) years after the initial date the provider delivered health care services to the member under contractual agreement with Community Care, regardless of termination of the contractual agreement.

The review of treatment record keeping practices, using a Medical Record Review Form is one component of the provider's credentialing site visit. Facilities not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA) must meet the record keeping standards established by Community Care. Record keeping must also meet all licensing regulations. The provider is sent the Medical Record Review Form instrument prior to the scheduled site visit.

The provider may prepare for the Medical Record Review by designating an actual treatment record for review, preparing a blinded treatment record, or preparing a mock-up treatment record for review. The purpose of the credentialing Medical Record Review is to ensure that the provider has resources in place to collect the information needed through all stages of evaluation and treatment. A score of 80% is required to pass the Medical Record Review. Providers are notified in writing if the score is below passing. When the score is below passing, the provider must submit a written corrective action plan. A follow-up Medical Record Review will be scheduled within **six** (**6**) **months** to monitor implementation of the provider's corrective action plan.

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

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

The performance goal for completeness of treatment record documentation is 80%. Aggregate results of the assessment of treatment record documentation are communicated periodically to behavioral health providers via *Provider Alerts* or newsletters.

Adverse Event Reporting (To Protect Patient Safety)

To promote care being delivered in a safe environment and being based upon clinically appropriate assessment and interventions, behavioral health providers are to identify and report **Adverse Events** involving UPMC Health Plan members.

Adverse Events include, but are not limited to:

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

Behavioral health providers must report adverse events within **two** (**2**) **business days** or sooner by calling the Provider Line (1-888-251-2224) or faxing the incident report to the Quality Improvement Department at 1-412-454-6240. Providers are also expected to comply with all applicable state and federal laws and professional and legal requirements regarding reporting of adverse events.

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

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

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

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

Provider Cultural Competency

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

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

Assessment of cultural competency includes evaluation of the diversity of providers in the behavioral health network and their documented experience in delivering culturally competent behavioral health care. UPMC Health Plan also evaluates member informational materials, including audiovisual materials, training documents, service pamphlets and radio or television public service announcements to assess if the material is appropriate to meet the cultural needs of its members.

Providers' cultural competency will be evaluated using instruments and methods that are consistent with cultural patterns and norms of the members being served. The instruments used will vary according to the specific cultural groups being surveyed. However, all instruments used will evaluate whether the provider understands the culture of the community being served and uses strategies to avoid breakdowns and pitfalls due to cultural insensitivity in the provision of care. During a Credentialing site visit, the provider is required to produce a written policy or policy statement regarding cultural diversity, awareness, and competence. Failure to have a written policy or policy statement results in a request for corrective action, which is required in order for the provider to "pass" the site visit standards. The Quality Improvement Department will review all complaints received related to cultural competency of providers, conduct trend analyses, and determine appropriate follow-up when needed. Providers' commitment is essential to our ongoing development of a responsive system of care.

Provider Performance Tracking

Provider Performance Tracking is the process of collecting, analyzing, monitoring, and reporting information about the activity and quality of the Behavioral Health Provider Network. Measures are chosen and developed in conjunction with behavioral health providers so that the indicators are meaningful to providers and can be impacted through their quality improvement efforts.

UPMC Health Plan analyzes aggregate network performance, making information available to providers through articles, committees, public forums, and Provider Performance Tracking reports.

Provider Satisfaction

Community Care and UPMC Health Plan welcome comments from behavioral health providers on the service they have received from our staff and on how we can improve provider services. Provider satisfaction surveys are regularly distributed to a random sample of network behavioral health providers to obtain provider feedback. We hope providers will take time to complete the survey when they receive it and return it to us.

If a provider is dissatisfied with any aspect of Community Care's or UPMC Health Plan's operations, we encourage them to express their concern by calling the Behavioral Health **Provider Line** (1-888-2512224). If an issue cannot be resolved informally, you may lodge a formal complaint. You may express your provider complaint orally or in writing. Use the following address to do so in writing:

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

Community Care Provider Relations
One Chatham Center, Suite 700
112 Washington Place
Pittsburgh, PA 15219

For all other provider complaints:

UPMC Health Plan Complaints Department
One Chatham Center, Suite 900
112 Washington Place
Pittsburgh, PA 15219

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

Provider Disputes

If a provider disagrees with a decision by the Health Plan to deny coverage of care or services, the provider has the right to formally dispute that decision. A provider dispute is a request from a provider without the written authorization from a member. A provider dispute does not substitute for a member grievance, since the provider is not acting on behalf of the member. Members maintain the right to file a member grievance. A member grievance may be initiated without regard to whether there were prior provider disputes in a case. A member grievance is processed under a different set of guidelines as determined by the appropriate governing agencies. Provider disputes fall into three (3) categories: Administrative, Medical Necessity, and Expedited.

Resubmitting a Corrected Claim Due to Minor Error or Omission Is Not a Provider Dispute.

Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address. (See *Claims Procedures* Section V of this chapter.)

A request for an administrative or a medical necessity Provider Dispute must be submitted in writing within 60 business days of the denial notification. The request must include the reason for the dispute and a copy of the medical record or other supporting documentation. The request for a dispute should clearly state why and on what basis the provider is disputing. To answer any additional questions about the right to or how to file a dispute, providers may call Provider Services at 1-866-918-1595.

Administrative Provider Disputes

Administrative Provider Disputes involve claims that have been denied for reasons other than those related to medical necessity. Therefore, administrative denials are not reconsidered based on medical necessity. Some examples are:

- The care was not coordinated with the PCP.
- Prior authorization was required but not obtained.

The following procedure outlines the administrative process:

1. Provider sends a written dispute to UPMC Health Plan.

The provider sends a written Provider Dispute to the Health Plan at the following address stating the reason the claim was denied (from the Explanation of Payment) and any supporting documentation as to why the provider believes the decision should be reversed.

UPMC Health Plan
Provider Disputes
PO Box 2906
Pittsburgh, PA 15230-2906

2. Committee reviews the denial.
A committee of Health Plan employees, including nurses and a medical director, decides administrative disputes. The committee reviews such disputes only once.

3. Committee makes decision.
The committee makes a decision within 60 business days. **All decisions are final.** If the administrative denial is upheld, the provider is notified in writing of the result within 10 business days of the decision. If the administrative denial is reversed, the claim is adjusted within 30 business days of the date of the decision.

Medical Necessity Dispute
Two levels of dispute are available to providers regarding denials based on medical necessity. Each is described in this section. UPMC Health Plan makes medical necessity determinations based upon specific criteria sets. Please refer to Chapter G for information on the criteria used to determine medical necessity.

First-Level Dispute
1. Provider sends a written dispute to UPMC Health Plan.
Within 60 business days of the denial notification, the provider sends a written dispute to the Health Plan by fax at 412-454-7920 or by mail at the following address:

UPMC Health Plan
Provider Disputes
PO Box 2906
Pittsburgh, PA 15230-2906

2. Physician reviews the dispute.
A Health Plan physician reviewer who was not involved with the initial determination reviews the dispute.

3. Physician reviewer makes a decision.
Within 30 business days, the Health Plan physician reviewer determines whether any additional information has been presented that supports a reversal of the denial.

4. Provider receives notification of the decision.
If the medical necessity denial is upheld, the provider is notified in writing of the result within 10 business days of the decision. If the medical necessity denial is reversed, the claim is adjusted within 30 business days of the date of the decision.

Second-Level Dispute

1. Provider submits a request for a Second-Level Dispute.

A provider who does not agree with the outcome of a medical necessity dispute can submit a request for a Second-Level Provider Dispute following the procedure listed in First-Level Decision letter.

2. Physician reviews the dispute.

A peer physician or physician of the same specialty of care that is being appealed reviews the dispute and makes a decision. Also, a Health Plan physician reviewer who was not involved with the previous determinations reviews the request.

3. Committee makes decision.

A committee, composed of Health Plan staff, a Health Plan physician, and an independent peer physician of the same specialty, reviews the dispute and makes a decision within 60 business days.

4. Provider receives notification of the decision.

If the medical necessity denial is upheld, the provider is notified in writing of the result within 10 business days of the decision. If the medical necessity denial is reversed, the claim is adjusted within 30 business days of the date of the decision.

Expedited Provider Dispute Alert

The provider can request an expedited review if the provider believes a member's life, health, or ability to regain maximum function is in jeopardy because of the time required for the usual review process.

A decision is rendered as quickly as is warranted by the member's condition, but no later than 48 hours after the review is received.

An expedited review can be requested by calling Medical Management at 1-800-425-7800. Clinical documentation is required.

Provider Education

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

Provider Advisory Committee

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

In addition, the Provider Advisory Committee nominates a minimum of two (2) providers bi-annually to serve as the provider representative to the Community Care Board of Directors. Community Care's Board chooses one (1) of the nominees to serve as a voting member of the Board for that Board term.

Other opportunities exist to join other Community Care and UPMC Health Plan committees that include behavioral health providers. If you would like to participate, please call the Behavioral Health Provider Line at1-888-251-2224.

New Technology

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

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

Availability of Behavioral Health Case Management Programs

UPMC Health Plan offers three behavioral health case management programs:

- A depression program for members who have been newly started on an antidepressant and have been diagnosed with depression; and
- An ADHD program for children diagnosed with ADHD who have been newly started on a stimulant medication (Family members are welcome to participate in the ADHD program.); and An outreach program for members recently discharged from inpatient behavioral health treatment and for any other members with behavioral health case management needs.

Members can access information and resources by calling Behavioral Health Case Management Services toll-free at **1-888-777-8754** to request information. TTY users can call **1-877-877-3580.**

The programs are free to UPMC Health Plan members and materials for the programs are designed to supplement information patients receive about diagnosis and treatment from their providers. If you would like more information about these programs, please call UPMC Health Plan Behavioral Health Services Case Management Services at **1-888-777-8754**.

Confidentiality and Disclosure Policies

Policies concerning confidentiality to guide both staff (UPMC Health Plan and Community Care) and providers in collecting, using, and disclosing information that is necessary and appropriate to provide high-quality services efficiently have been developed. The policies cover information created by UPMC Health Plan and Community Care as well as information acquired in connection with both organizations' business activities. The confidentiality policies are intended to meet requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) and apply to, but are not limited to, all member information, provider information (including credentialing/assessment, contracting, and provider tracking), and Quality Improvement Program documents and meeting minutes.

The confidentiality policies and procedures describe in detail how both UPMC Health Plan and Community Care protect members' rights and responsibilities related to privacy in all settings. The policies outline how members are to know what information is routinely gathered about them and how it is used, so that members can review this information (including their medical records) and authorize disclosure of their member-identifiable information in special circumstances (including disclosure to employers or plan sponsors). The following sections highlight Community Care's and UPMC Health Plan's Confidentiality Policies and Procedures that may apply to behavioral health providers (who are "contractors" of Community Care). The topics regarding member-identifiable information that are covered in the following sections include:

- What constitutes member, provider and Community Care confidential information (**See page 39.**)
- How to handle confidential information (**See page 40.**)
- How to maintain confidentiality when transferring information by mail, fax and e-mail (**See page 41.**)
- Destroying confidential information (**See page 41.**)
- Collecting and using member-identifiable information (**See page 42.**)
- Informing members about confidentiality (**See page 43.**)
- Who is able to give informed authorization for release of member-identifiable information (**See page 43.**)
- Member access to utilization records (**See page 44.**)

- Disclosure of member-identifiable information, including disclosure without authorization of the member/member representative, validity of authorization and verbal authorization for release of information (**See page 45.**)
- Disclosure of information to employers or plan sponsors (**See page 45.**)
- Requirements for provider storage and transmission (by e-mail or fax) of member-identifiable information

The policies on confidentiality describe for employees, representatives (including providers), and members the procedures on obtaining authorizations for use of member medical information, allowing members access to their medical records held by providers, and protecting access to member "protected health information" as defined by HIPAA.

General Confidentiality Provisions

Agents and contractors (including providers) of both Community Care and UPMC Health Plan potentially having access to confidential information are required to agree to be bound by strict confidentiality policies and procedures, or must conform to equivalent provisions as determined by Community Care's and UPMC Health Plan's staff or legal counsel. Breach of the Confidentiality Agreement or equivalent is grounds for immediate Termination With Cause (**See page 44.**).

What Constitutes Confidential Information

The following are highlights of what constitutes confidential information:

- Member-identifiable data and information, including **explicitly identifiable** data such as member name, social security number, or other identifier that can be directly linked to a specific individual and **implicitly identifiable** data such as member address, telephone number, date of birth, or other information that, alone or in combination with other available information, can lead to identification of a specific individual, are **confidential**.
- Data and information specific to providers, including, but not limited to, that used for network development, credentialing, performance evaluation, quality assurance, quality improvement, and peer review are **confidential**. A provider's name, professional degree, status as a member of the Behavioral Health Provider Network, business address, business telephone number, and specialty/specialties or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes. Data and information related to a provider's racial, cultural, or ethnic background, age, religious affiliation, gender, and ability to communicate in languages other than English are **confidential** unless the provider explicitly authorizes the release of this information. **For example**, **completing optional sections of the provider credentialing/recredentialing or assessment/reassessment application regarding a provider's ability to communicate in languages other than English may be used to help fulfill members' requests when making referrals**.

- Information specific to a practitioner practice group or facility, including, but not limited to, that used for network development, organizational assessment and contracting, performance evaluation, and certain quality improvement activities is **confidential**. However, a practitioner practice group or facility name, status as a participant in the Behavioral Health Network, business address, business telephone number, and services offered are not considered confidential when disclosed for legitimate business purposes.
- Managed care business data and information, including, but not limited to: salaries; policies and procedures; finances; business plans; information about providers participating in the network when not being released for legitimate business purposes; proposals to potential or current customers; information disclosed to Community Care or UPMC Health Plan in confidence by any third party; and performance evaluation and certain quality assurance data/information where providers are individually identifiable are **confidential**.

Keeping Information Confidential

- For all staff representatives:
    1. Divulging computer passwords and security system pass codes is prohibited;
    2. Divulging access codes and keys with any individual who does not have the right to such access codes or keys is prohibited;
    3. All computers that have the ability to access confidential data or information must be protected with a confidential log-in password; turned off or logged off at the end of the workday; and protected with a confidential screen-saver password in the event that the computer is turned on and logged on while the computer user is away from his or her work area.
- All agents, contractors (including providers), employees, staff, and volunteers may not access or view confidential data or information unless required by their duties or responsibilities for, or on behalf of, Community Care or UPMC Health Plan.
- All agents, contractors (including providers), employees, staff, and volunteers may not discuss confidential data and information in an area where individuals, including other agents, contractors, employees, staff, and volunteers who do not have the right to know about the information, may overhear the information.
- All confidential data and information must be maintained in a manner that prevents access by individuals who do not have a right to access the data and information. All physical media, including, but not limited to, paper, magnetic, and optical, used to store confidential data and information must be stored under a double-lock system. All physical media containing confidential information that are still in use by Community Care or UPMC Health Plan agents, contractors (including providers), employees, staff, and volunteers at the end of the day must be locked in that individual's desk or in another secured storage area. All desks or secured storage areas must be in areas with keyed entry, maintaining a minimum of a dual-key system. All physical media containing confidential information that are no longer needed by Community Care or UPMC Health Plan agents, contractors, employees, staff, and volunteers must be returned to locked master storage at the end of the day. All electronic media containing confidential information must be password-protected.

Transferring Confidential Information

The transfer of confidential information for legitimate business purposes between agents, contractors (including providers), employees, staff, and volunteers in their official capacities as representatives of either Community Care or UPMC Health Plan is considered an internal transfer, even though they may be in different physical locations. The transfer of confidential information other than to each organization's internal agents, contractors, employees, staff, and volunteers in their official capacities as representatives of Community Care or UPMC Health Plan is considered an external transfer and must be made in accordance with policies regarding Authorization to Disclose Information.

- The internal transfer of all confidential data and information must be conducted in a manner that limits potential access by individuals who do not have a right to access the data and information. When not hand-carried and personally delivered to the recipient, physical media containing confidential data and information must be placed in a sealed envelope marked "Confidential."
- Confidential data and information sent by facsimile must bear a prominent confidentiality notice similar to the following:
- "This facsimile transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by facsimile or telephone and destroy this document."
- Confidential data and information sent by e-mail must be flagged as confidential and bear a confidentiality notice similar to the following within the message:
- "This e-mail contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this e-mail in error, please notify the sender by return e-mail, securely delete this file and any electronic or magnetic copies, and destroy any paper copies."
- Community Care and UPMC Health Plan do not transmit Protected Health Information (PHI) via e-mail to any source outside of the UMPC intranet system.

Destroying Confidential Information

Confidential data and information no longer required for legitimate business purposes must be destroyed in a secure manner. Paper records must be thoroughly shredded. Magnetic files must be deleted in a manner that does not permit the files to be undeleted, for example, by reformatting a floppy disk using the "secure" format option. Either optical storage media must have the files securely deleted or, if this is not possible, the storage media must be destroyed.

Oversight of Confidentiality

The privacy officer and the Compliance Department are responsible for approving and periodically reviewing all policies and procedures related to confidentiality and for identifying, developing, and implementing mechanisms to oversee the implementation and application of

Community Care's and UPMC Health Plan's confidentiality policies and procedures. Highlights of these responsibilities include the following:

- At least annually, the Compliance Department and privacy officer will evaluate ways to (**1**) reduce the collection of member-identifiable data and information and (**2**) aggregate or de-identify such data and information as close to the collection point as possible, as identified by surveying staff representatives, holding workgroup sessions with staff representatives, and evaluating complaints.
- The privacy officer is responsible for reviewing and approving member information, including information about confidentiality policies and procedures pertaining to members.
- Both Community Care and UPMC Health Plan have identified circumstances necessitating special protection of member-identifiable data and information. Requests for special protection of member-identifiable information are referred to the respective privacy officer, who will consider the request, determine whether it should be honored, and notify the requestor of the decision. If the request is honored, the privacy officer will determine the mechanism to adhere to the request and update the procedure on internal handling of member-identifiable information to reflect the addition. If the privacy officer determines not to honor the request, the requestor will be notified of his or her right to appeal the decision through the appeals process.
- All member and provider concerns regarding confidentiality shall be logged as complaints. Complaint appeals are handled through UPMC Health Plan.
- UPMC Health Plan, reviews requests for access to member-identifiable data and information.

Collecting and Using Member-Identifiable Information

UPMC Health Plan and Community Care collect and use member-identifiable data and information routinely in the performance of their work. Purposes for which data and information are routinely collected include, but are not limited to:

- Verification of member eligibility for services
- Management of behavioral health benefits, including prospective, concurrent, and retrospective reviews, and decisions regarding coverage for requested treatment
- Coordination of care
- Billing
- Adjudication of claims
- Performance measurement and improvement ("quality assurance")
- Compliance audits
- Prevention and disease management activities
- Provider credentialing
- Investigating and resolving inquiries and complaints
- Processing appeals
- Complying with regulatory requirements and accreditation standards

Members are notified of the routine collection and use of member-identifiable data and information for the purposes just described. The use of member-identifiable information for other purposes beyond treatment, payment, and operations functions requires written authorization from the member or member's representative, unless use of the information is permitted or required by applicable law or a valid court order.

Informing Members About Confidentiality

UPMC Health Plan prepares information that describes its confidentiality policies and procedures for members. This information covers key points of the information such as:

- Collecting and Using Member-Identifiable Information
- Handling of Member-Identifiable Information
- Ability to Give Informed Authorization
- Member Access to Utilization Records
- Disclosure of Information
- Disclosure of Information to Employers or Plan Sponsors
- An Accounting of Disclosure of Member Protected Health Information to Members
- Amending Protected Health Information by the Member

Information about confidentiality is distributed by UPMC Health Plan to members in:

1. Member rights and responsibilities statement;
2. Member instructions on how to obtain care, appeal a coverage decision, and access Member Services support; and
3. Descriptions of the member complaint process.

Information about confidentiality is sent to members annually via UPMC Health Plan member newsletters, evidence of coverage documents, and/or handbooks. The members' Notice of Privacy is also posted on the Health Plan's website at http://www.upmchealthplan.com/privacy/index.html.

Ability to Give Informed Authorization for Release of Member-Identifiable Information

UPMC Health Plan or Community Care obtains special authorization from members or member's representative to release member-identifiable information, as described in the procedure for Disclosure of Information. The following determinations regarding the giving of valid authorization for the release of member-identifiable health information have been made:

- A member who has reached the age of majority as identified by member eligibility data is capable of giving informed authorization for release of information on his or her own

behalf unless UPMC Health Plan or Community Care have received notification that the member has been adjudicated incompetent.

- The natural or adoptive parent of a minor member, as identified by member eligibility data, is capable of giving informed authorization for release of information on behalf of the minor member unless UPMC Health Plan or Community Care have been informed that the parent has been adjudicated incompetent, the parent is not the legal guardian of the minor member, or the minor member has been legally emancipated.
- An emancipated minor member is capable of giving informed authorization on his or her own behalf. If not already on file with UPMC Health Plan or Community Care, proof of the minor member's status will be requested from the minor member before honoring the authorization for release of member information.

UPMC Health Plan and Community Care expend all reasonable effort to develop and maintain an accurate and efficient system for identifying who is eligible to give valid authorization for release of member-identifying information. Having established such a system, UPMC Health Plan and Community Care reasonably rely on the **absence** of information indicating that a member or parent of a minor member has been adjudicated incompetent or that a parent is not a minor member's legal representative, for accepting an authorization for release of information as valid. Verifying that a member or parent of a minor member is competent would place an undue burden on UPMC Health Plan or Community Care and in most instances would require a breach of confidentiality.

When UPMC Health Plan or Community Care is informed that a member is unable to give special authorization for the release of information, UPMC Health Plan or Community Care will accept authorization from and/or release records to a representative legally authorized to approve (authorize) the release of, or to receive, a member's personal health information. Or UPMC Health Plan or Community Care will require written proof of the individual's status as a legally authorized representative of the member and that the legally authorized representative's status covers the area for which the authorization for information is being sought.

Individuals capable of giving valid authorization for the **release** of member-identifiable health information are also entitled to have **access** to that information, **except** that parents or guardians of children age 14 years or over may not have access to the child's health information without the authorization of the child.

Member Access to Utilization Records

In accordance with HIPAA Section 164.524, members may request to access their utilization file. The member may request to view his/her information by contacting UPMC Health Plan Behavioral Health Services Department.

Disclosure of Member-Identifiable Information

Except as described in the procedures for Collecting and Using Member-Identifiable Information (**See page 42**), Disclosure Without Authorization of Member to Member Representative (**See page 45**) and Disclosure of Information to Employers or Plan Sponsors (**See page 45**), UPMC Health Plan and Community Care request authorization from the member or member's legally authorized representative before disclosing member-identifiable data or information. The member or the member's legally authorized representative has the right to deny the request to release member-identifiable information without consequence for the member or the member's coverage.

If member-identifiable data and information are to be disclosed for purposes other than described in the procedures for Collecting and Using Member-Identifiable Information (**See page 42**), Disclosure Without Authorization of Member or Member Representative (**See page 45**), and Disclosure of Information to Employers or Plan Sponsors (**See page 45**), the authorization of the member or member's legally authorized representative is required. Times when authorization of the member or member's legally authorized representative is required include:

1. Before disclosing member-identifiable data and information for research purposes;
2. Before disclosing the member's behavioral health signs, symptoms, diagnoses, or treatment to a primary care physician (PCP) or other clinician not providing behavioral health care to the member; and
3. When disclosing the member-identifiable data and information that could knowingly result in the member's being contacted by another organization for marketing purposes.

Whenever member-identifiable information is disclosed, only that information necessary to accomplish the purpose of the disclosure is released.

Disclosure Without Authorization of Member or Member Representative

Member-identifiable information can be disclosed without authorization of the member or the member's legally authorized representative in the following circumstances:

- When such disclosure to health care personnel, a health care facility, the member's identified significant other, or the police is required to prevent loss of life or injury to the member
- When authorized by an appropriate and valid court order
- When authorized by UPMC Health Plan's or Community Care's legal counsel to meet the requirements of any applicable state or federal law
- To report child abuse or neglect
- To meet public health reporting requirements
- To the Pennsylvania Department of Health, Pennsylvania Department of Welfare and the Pennsylvania Insurance Department for the monitoring of health care systems, government programs, and compliance with civil rights laws
- To federal officials for intelligence, counterintelligence, or other national security activities authorized by law
- When required by Protective Services for the President of the United States and others

- To military command authorities in order to provide medical information about a member serving in the armed forces
- When it concerns Workers' Compensation
- To coroners and medical examiners
- Information about inmates of a correctional institution or under the custody of a law enforcement official may be released to that institution or official

Validity of Authorization to Release Member Information

UPMC Health Plan and Community Care consider an authorization to release member-identifiable information to be valid only if:

The member or member's legally authorized representative is informed of the specific information to be released and the purpose(s) of the release in language which he or she can understand; **AND**

- The member or member's legally authorized representative is informed that the provision of care or treatment will not be affected by the decision of the member or member's legally authorize**d** representative;
- **AND**
- The authorization is obtained in a manner that complies with applicable laws and regulations.

Written and Verbal Authorization for Release of Information

The authorization to release information should be in writing. However under some circumstances it may be necessary to obtain authorization verbally. The use of a verbal authorization should be approved in advance by UPMC Health Plan's or Community Care's legal counsel or, if circumstances indicate the need for a rapid decision about the acceptability of a verbal authorization, by a member of UPMC Health Plan's and/or Community Care's senior management. The written authorization must include provision of the following information:

- The name of the person or entity providing the information
- The specific information to be released
- The purpose for the release
- The individual or entity authorized to receive the information
- The expiration date of the authorization
- The signature of the member or member's legally authorized representative
- The address of the member or member's legally authorized representative
- The signature of the witness
- The date of the authorization

Two representatives of UPMC Health Plan or its affiliate Community Care (such as employees, staff, or practitioner providers) must witness the entire process of obtaining verbal authorization to release information.

Disclosure of Information to Employers or Plan Sponsors

UPMC Health Plan and Community Care do not share member-identifiable data or information with employers without authorization of the member or the member's legally authorized representative.

Staff must verify that the member has signed an authorization to release such data or information to the employer before any information is shared. The employer is required to agree in writing to protect all member-identifiable data and information from being used in any decisions affecting the member.

When an employer requests member-identifiable information, staff will inquire as to the proposed use of the data and information and attempt to meet the need with data and information that are not member-identifiable, for example, aggregated data or information. When member-identifiable data or information is required, staff will attempt to satisfy the employer's request with data or information that is implicitly, not explicitly, member-identifiable.

Although the identification of specific employees is still possible with implicitly member-identifiable data or information, the probability is less and therefore affords greater protection for the member.

In all instances, staff discloses only that information necessary to accomplish the purpose of the disclosure.

Handling of Practitioner-Specific Information

UPMC Health Plan and Community Care consider practitioner-specific data and information, including but not limited to, that information used for network development, credentialing/assessment, performance evaluation, select quality assurance activities, compliance audits, and peer review, to be **confidential** to the extent permitted by law. A practitioner's name, professional degree, status as a member of a Behavioral Health Provider Network (affiliated with Community Care and/or UPMC Health Plan), business address, business telephone number, specialty (or specialties), and self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.

Data and information related to a practitioner's racial, cultural, or ethnic background; age; religious affiliation; gender; and ability to communicate in languages other than English is confidential unless the practitioner explicitly authorizes the release of this information. For example, if the practitioner volunteers the information on the credentialing/assessment form that the practitioner has the ability to communicate in languages other than English, this information

may be used by UPMC Health Plan and Community Care to meet specific member needs or requests when making referrals.

Regarding Files of Practitioner Information Maintained at Community Care:

- Physical files are maintained in a locked room or locked file cabinet when not being used by Credentialing Staff or the Credentialing Committee.
- Practitioner files stored in electronic, magnetic, or optical format are protected with a secure password.
- Access to practitioner files is limited to Credentialing Department staff, Credentialing Committee, Network Management staff, and the Compliance staff.
- Upon request, practitioners may review information in their file, except for any information from the National Practitioner Data Bank (NPDB). Review of NPDB information is prohibited by federal statute.
- Practitioners are informed of the right to review information in their file through the cover letter in the application packages for credentialing/recredentialing or assessment/reassessment.
- Practitioners may obtain a copy of their file by making the request in writing. Credentialing staff will send a copy of the practitioner's file, marked "Confidential," to the practitioner within **10 business days** of receipt of the written request for the file. NPDB information and peer review (Peer Reviewer) information is not included in the file sent to the practitioner.

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

Practitioners have the right to correct erroneous information by submitting corrections in writing or sending additional documents to the Credentialing Department. Credentialing staff document in the file any verbal information or corrections provided by the practitioner, including the date and signature of the individual who obtains the information.

Provider Confidentiality

Behavioral Health Network Providers are responsible for maintaining confidentiality in the collection, use, and disclosure of member-identifiable information. Requirements are as follows:

- Member-identifiable data and information (such as medical records, appointment books, correspondence, laboratory results, billing records, and treatment plans), whether paper-based or on removable electronic data storage media, must be maintained under lock and key, either in locked cabinets or in a locked area. The data storage area must be separate from public areas such as waiting rooms, areas where services are delivered, and any other areas accessible to unauthorized persons. When unlocked, paper records and

removable computer storage media must be maintained in a secure location where they are not accessible and their content is not visible to unauthorized individuals.

- When **computers** are used to store member-identifiable information, they must be password-protected (unless all persons at the site are authorized access and the computers are in secure locations not accessible to unauthorized individuals). Computer monitors must be positioned such that they are not visible to unauthorized individuals.
- If electronic mail (**e-mail**) is used to transmit member-identifiable data or information, providers must follow their own internal policies on electronic unsecured transmission of PHI to properly safeguard the information.
- Telefacsimile (**fax**) machines must be located where faxes may not be intercepted or viewed by individuals not authorized to access member-identifiable information. When member-identifiable information is transmitted by fax, a confidentiality notice similar to the following must be prominently displayed on the cover sheet:

  > "This facsimile transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by facsimile or telephone and destroy this document."

Please call the **Provider Line** (**1-888-251-2224**) for any authorization for release of information forms that might be needed in the care of UPMC Health Plan members. When the Provider Line answers, press "1" and when prompted, press "1" for UPMC Health Plan.

Quality Improvement Overview

The quality of health care UPMC Health Plan members receive is very important. At UPMC Health Plan, considerable resources are dedicated to improving the health care experience of members. Our Quality Improvement Program is overseen by a Quality Improvement Committee comprised of clinicians — including behavioral health specialists — dedicated to improving quality of care and service to members.

More Information and Suggestions for UPMC Health Plan's Quality Improvement Program: If you would like more information about UPMC Health Plan's Quality Improvement Program — including goals, processes, and outcomes — please contact UPMC Health Plan's Provider Services Line at **1-888-918-1595** and ask to speak to a Quality Improvement staff member. A hard copy of information about Quality Improvement (which is posted on UPMC Health Plan's website) is available upon request.

If you have any suggestions regarding how to improve UPMC Health Plan's Quality Improvement Program, please contact us at:

UPMC Health Plan
Quality Improvement Department
One Chatham Center, Suite 900
112 Washington Place
Pittsburgh, PA 15219

Member Satisfaction

Member satisfaction is one of the highest priorities for UPMC Health Plan, and is annually assessed to better meet the need of our members. Information from the behavioral health member satisfaction survey is regularly used by UPMC Health Plan's Quality Improvement team to develop a more comprehensive plan for improving and maintaining member satisfaction. Results from member satisfaction surveys have led to initiatives to streamline UPMC Health Plan operations, improve customer services, and collaborate and communicate more effectively with network providers about health care delivery and the experience our members want and need.

Information About Complaint and Grievance Procedures

Please see the information at www.upmchealthplan.com for details regarding UPMC Health Plan's Complaint and Grievance Procedures.

Fraud and Abuse Reporting

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

Fraud: Health care insurance fraud is defined as the submission by a health care provider or enrollee of false or knowingly inaccurate or deceptive information to a health insurance carrier or vendor (or one of their providers) for the purposes of obtaining reimbursement or provision of services for which the recipient of said reimbursement or services is not entitled. This definition shall also include any health insurance carrier employee who knowingly aids, abets, or colludes with providers or enrollees in their receiving reimbursement or services to which they are not entitled. Examples of fraud could include a provider submitting a bill for a service that did not occur, billing for a time period greater than the time actually spent with the member, or billing for provision of a service that did not meet the service definitions.

Abuse by a provider would be defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the UPMC Health Plan or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. "Abuse" also includes member practices that result in unnecessary costs to UPMC Health Plan. Examples of abuse include providers' billing for unnecessary or excessive services or providers' performing a laboratory test on large numbers of patients when the provider knows only a few should have it.

Any UPMC Health Plan staff member suspecting fraud must report the suspicion, either to his or her supervisor or directly to UPMC Health Plan's Special Investigations Unit (SIU). If the supervisor is notified first, he or she must report the suspicion to the SIU within one (1) business day of receiving the staff member's report. The SIU then conducts an investigation per UPMC Health Plan Policy.

When fraud or abuse is confirmed, UPMC Health Plan reports the fraud or abuse to appropriate licensing, reporting, and investigative agencies and takes appropriate action to prevent future fraud or abuse. Consequences of confirmed fraud include at least repayment of monies paid for the fraudulent claims and the requirement to submit a plan of corrective action to prevent reoccurrence. Suspension, exclusion from the Behavioral Health Network of providers, and levying of a fine are possibilities in addition to the notification to appropriate licensing, reporting, and investigative agencies.

Provider Actions to Avoid Fraud and Abuse: UPMC Health Plan encourages behavioral health providers to read this Provider Manual and/or call the Provider Line at 1-888-251-2224 with any questions about standards of care, documentation and record keeping, claims/billing procedures, or any other activity that could be associated with a fraud or abuse concern. In addition, UPMC Health Plan's affiliate Community Care offers provider training on these and other topics.

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

UPMC Health Plan Claims Procedures

Information about submitting claims for services provided to UPMC Health Plan members can be found in the UPMC Health Plan Claims Procedures Handbook located at www.upmchealthplan.com. UPMC Health Plan updates this handbook periodically. Please contact the UPMC Health Plan Claims Department at **1-888-876-2756** with any questions regarding claims.

Appendix A

Glossary of Terms and Abbreviations Prepared for the Behavioral Health Provider

The following terms and abbreviations are defined as they are used in the Behavioral Health Section of the UPMC Health Plan Provider Manual.

A

Abuse
Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the managed care program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; also UPMC Health Plan member practices that result in unnecessary cost to the managed care program

Adverse determination
A determination as to whether or not requested or provided health care services are:

- Adequate and essential for the evaluation or treatment of a disorder as defined by standard diagnostic nomenclature (the most recent or approved version of either ICD or DSM)
- Consistent with the standards of good medical practice, required for other than convenience, and the most appropriate supply or level of service

Adverse Event
An event involving member safety that must be reported to UPMC Health Plan and to other agencies as appropriate; also known as Significant Member Incidents

ALOS
Average length of stay at a hospital or treatment program

Appeal
A request to reconsider and change a Proposed Resolution to a Complaint. It is UPMC Health Plan's Proposed Resolution to a Complaint that is the subject of the Appeal

ASAM
American Society for Addiction Medicine; ASAM principles and level-of care criteria constitute UPMC Health Plan's medical necessity criteria for adolescent chemical dependency

Assessment
The process that facility providers complete similar to credentialing for individual behavioral health practitioners

Authorization
An agreement that the services planned for a specific member meet Medical Necessity (level of care) criteria; a provider must receive authorization to provide certain behavioral health services for a claim to be honored, but receiving authorization is **not** a promise that the claim will be paid — other criteria must be met

C

CARF
Committee on Accreditation of Rehabilitation Facilities

CMS
Center for Medicare and Medicaid Services

COA
Council on Accreditation

Complaint
An individual who expresses dissatisfaction with UPMC Health Plan or its affiliate Community Care, a provider, or other entity, verbally or in writing; a complainant may include members, subscribers, practitioners, family members of a member, and member representatives among others

Coordination of care
Coordination of behavioral health care with a UPMC Health Plan member's primary care physician (PCP) or other provider, including behavioral health specialists

Cultural competency
The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into appropriate practices in the delivery of behavioral health services; assessment includes network providers' policies and readiness to address the cultural needs of members

E

EOP (Explanation of Payment)
A form used by the UPMC Health Plan Claims Department providing an explanation to the provider about payment for a particular claim

Expedited grievance
A request to change an adverse determination related to a request for medical care or treatment in which use of the time frames for Preservice Grievances (**a**) could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or (**b**) concerning admission, continued stay, or other behavioral health services for a member who received emergency services and has not been discharged from a facility, and (**c**) that, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

F

Facility
An institution, organization or program licensed, or otherwise authorized, to provide health care services under applicable state or federal laws or the laws of another appropriate jurisdiction, including, but not limited to, freestanding psychiatric hospitals, psychiatric and addiction disorder treatment units in general hospitals, partial hospitalization programs, psychiatric and addiction disorder residential treatment centers, community mental health centers, and ambulatory psychiatric and addiction disorder treatment facilities and clinics

Fraud
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

G

GAF (Global Assessment of Functioning)
Score on the most current version of the DSM Axis V

H

HCFA (Health Care Financing Administration)

The former name of the federal agency that regulates health care spending and provides federal oversight for state health care spending agencies. This agency was renamed Centers for Medicare and Medicaid Services (CMS)

HEDIS (Healthcare Effectiveness Data and Information Set)
One of the most widely used sets of health care performance measures in the United States, which is developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS measures are designed to collect, assess, report on, and improve the quality of health care

HIPAA (Health Insurance Portability and Accountability Act)
A federal law addressing the privacy and confidentiality of patient information

J

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

L

Life-threatening emergency
As a result of a mental illness or substance use disorder, there is reason to believe the member is, or may become, homicidal or suicidal or the member or member's victim may suffer a disabling or permanent physical injury as a result of the member's behavior or condition; the assessment that a life-threatening emergency exists is based upon statements or behavior, member self-report, clinical judgment, or information obtained objectively

LOC (Level of care)
The particular setting that a member receives care such as inpatient hospitalization, partial hospitalization, or outpatient setting

LOF (Level of functioning)
A general term regarding the member's ability to perform particular functions such as daily living skills and employment. It is often measured by such scales as the DSM Global Assessment of Functioning (GAF)

LOS (Length of stay)
Continuous days of service for an admission to a facility or program

M

MBHO
Managed behavioral health care organization such as Community Care

MCO
Managed care organizations such as a physical health managed care organization (like UPMC Health Plan) or a managed behavioral health care organization (like Community Care)

Medical necessity criteria
Written, objective criteria, based on sound scientific evidence, clinical principles, and expert opinion used to determine the appropriateness of treatment interventions

Member grievance
A request from a member, member representative, subscriber, or treating practitioner (who has written authorization from the member) for UPMC Health Plan to reconsider and change a decision, such as a Medical Necessity decision (see also provider dispute)

Mihalik manual
The Mihalik Group manual containing medical necessity criteria for mental health treatment services

N

NCQA
National Committee for Quality Assurance

Non-life threatening emergency
As a result of a mental illness or substance use disorder, the member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within one hour

P

PCP
Primary care physician

PCPC (Pennsylvania Client Placement Criteria)
Medical necessity criteria set utilized by UPMC Health Plan for adult chemical dependency treatment services

Peer Advisor
A licensed physician or doctoral-level behavioral health clinician, legally authorized to practice independently, who assists in making utilization management decisions; a peer advisor may only review care or service that he or she would be able to provide under the scope of his or her clinical license; denials of care or service based on clinical criteria (Medical Necessity Denials) may only be issued by peer advisors

PHMCO
Physical health managed care organization

Post-Service review
Any review for care or services that have already been received; also known as a retrospective review

Practitioner
A clinician licensed, certified, registered, or otherwise legally authorized to practice independently by applicable state or federal regulation

Provider
A term that encompasses both practitioners and facilities

Provider Dispute
A request from a provider without the written authorization from the member to reconsider and change a decision (such as a Medical Necessity decision)

PsychConsult™
The computer software database program Community Care uses to record and report data for providers and members

R

Reassessment
The process that facility providers complete similar to recredentialing for individual practitioner; reassessment occurs every three (3) years

Routine need for care
The member exhibits signs or symptoms of a mental illness or substance use disorder that indicate the need for assessment and/or treatment without evidence of imminent or impending risk to the member or others or of an acute, significant change in level of functioning

S

Subscriber
An individual who has contracted for, or who participates in, coverage under a health insurance policy, health maintenance organization contract, or other benefit program with UPMC Health Plan providing payment, reimbursement, or indemnification for the costs of health care for the individual and/or eligible dependents of the individual

U

Urgent need for care

Either of the following constitutes an urgent situation: (**a**) as a result of a mental illness or substance use disorder, a member is experiencing signs, symptoms, or impairment in functioning that would likely require an intensive level of care within 24 hours if treatment is not provided; **OR** (**b**) a member expresses a readiness for, or amenability to, treatment if initiated within a 24-hour period