Provider Standards and Procedures

Provider Rights, Responsibilities, and Roles

Provider Rights

Providers have a right to:

- Be treated by their patients and other health care workers with dignity and respect.
- Receive accurate and complete information and medical histories for Members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in Members' treatment plans.
- Expect Members to follow their directions, such as taking the right amount of medication at the right times.
- Help Members make decisions about their treatment, including the right to recommend new or experimental treatments.
- Make a complaint or file an appeal against UPMC Health Plan and/or a Member.

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

- Receive payments for copayments, coinsurance, and deductibles as appropriate.
- File a grievance with UPMC Health Plan on behalf of a Member, with the Member's consent.

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

- Have access to information about UPMC Health Plan's Quality of Care programs, including program goals, processes, and outcomes that relate to Member care and services. This includes information on safety issues.
- Contact UPMC Health Plan Provider Services with any questions, comments, or problems, including suggestions for changes in the Quality of Care Program's goals, processes, and outcomes related to Member care and services.

- To request a peer-to-peer discussion with a UPMC Medical Director via telephone regarding prior authorization request denials during normal business hours and outside of normal business hours subject to reasonable limitations of availability. Providers should contact **Clinical Operations/Utilization** at **412-454-2765,** Monday through Friday from 8 a.m. to 5 p.m.
    - **UPMC Community HealthChoices, UPMC *for Kids*, UPMC *for You,* UPMC Health Plan (Commercial):**
      Prior authorization request denials are available for discussion from the time of denial until the internal grievance process or internal adverse benefit determination appeal process commences.
    - **UPMC *for Life,* UPMC *for Life* Complete Care (HMO D-SNP):**
      For Medicare plans, peer-to-peer reviews **cannot** be used to overturn cases. When the prior authorization case is denied, the provider will need to submit an appeal with the Complaints and Grievances Department. An appeal can be filed **within 60 calendar days** of the denial.

> ➢ **See:** ***UPMC Health Plan Provider Manual chapters for additional information:***
>
> - ***Provider Disputes, Initiating an appeal on behalf of the Member,*** Chapter B, Provider Standards and Procedures.
> - ***Peer-to-Peer Discussions,*** Chapter G, Utilization Management and Medical Management.
> - ***Peer-to-Peer Discussions,*** Chapter J, Pharmacy Services.

Provider Responsibilities

Providers have a responsibility to:

- Comply with state agency and federal regulations including the disclosure (at a practice level) of ownership, controlling interest, and management information.

> ➢ **See:** ***Disclosure of Ownership and Control,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures for full details.

- Follow all state and federal laws and regulations related to patient care and patient rights.
- Treat Members with fairness, dignity, and respect.
- **Not** discriminate against Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency, as described in Title VI Civil Rights Act of 1964 at **justice.gov/crt/about/cor/coord/titlevi.php.**
- Maintain the confidentiality of Members' protected health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

> ➢ **See:** ***Provider Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

- Provide Members with a notice of privacy practices that complies with all regulatory requirements including clearly explaining their privacy rights, the provider's obligation to protect Members' protected health information, and how to contact the provider and file a complaint.

> ➢ **See:** ***Provider Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

- Provide Members with an accounting of the use and disclosure of their protected health information in accordance with the requirements set forth under HIPAA.

> ➢ **See:** ***Provider Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

- Allow Members to request restriction on the use and disclosure of their protected health information.

> ➢ **See:** ***Provider Role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

- Provide services that are medically necessary.

> ➢ **See:** ***Medically Necessary,*** UPMC Health Plan Provider Manual, Chapter K, Glossary and Abbreviations.

- Provide Members, upon request, with access to inspect and receive a copy of their protected health information, including medical records.

> ➢ **Note:** Requests for copies of bills or other protected health information documentation by a Medical Assistance Member, their personal representative, or an attorney or insurance carrier for the purpose of legal action should be referred to the Department of Human Services' Division of Third-Party Liability, as directed in **Medical Assistance bulletin #99-09-03, "Clarification of Procedures for Requesting Copies of Medical Assistance Recipients' Bills."**

- Tell a Member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment.

- Collaborate with other health care professionals who are involved in the care of Members.

- Obtain and report to UPMC Health Plan any information regarding other insurance coverage.
- Allow a Member who refuses treatment or requests to stop treatment the right to do so, as long as the Member understands that, by refusing or stopping treatment, the condition may worsen or be fatal.

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

- Respect Members' advance directives and include these documents in their medical records.

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

- Allow Members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their treatment decisions.
- Allow Members to obtain a **second** opinion, and answer Members' questions about how to access health care services appropriately.
- Identify and report suspected cases of abuse or neglect and follow reporting procedures according to the PA reporting requirements.
- Allow UPMC Health Plan to use physician and provider performance data for quality improvement activities.
- Review clinical practice guidelines distributed by UPMC Health Plan.
- Notify UPMC Health Plan in writing, **90 calendar days** in advance, if the provider is leaving or closing a practice.
- Comply with UPMC Health Plan's Utilization Management program.

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

- Contact UPMC Health Plan to verify Member eligibility or coverage for services, if appropriate.
- Invite Member participation, to the extent possible, in understanding any medical or behavioral health problems that the Member may have and to develop mutually agreed-upon treatment goals, to the extent possible.
- Provide Members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.

- Disclose overpayments or improper payments to UPMC Health Plan.
- Provide clear and complete information to Members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow each Member to participate in the decision-making process.
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.

Closer Look at Interpreters and Cost

The Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 U.S.C. §12101, et seq., states that:

- Health care professionals or facilities **cannot** impose a surcharge on an individual with a disability directly or indirectly to offset the cost of the interpreter.
- The cost of the interpreter **should** be treated as part of overhead expenses for accounting and tax purposes.
- Tax relief is available for expenditures made toward interpreters.
- The Internal Revenue Service **may** allow a credit. This tax credit **may** be applied to reasonable and necessary business expenditures made in compliance with ADA standards in order to provide qualified interpreters or other accessible tools for individuals with hearing impairments.

Closer Look at Communicating Effectively

Providers have access to materials that help facilitate a Member's request for interpretation services. Providers can order language interpretation resource materials from the **Provider Marketing Materials** section of Provider OnLine, which can be accessed at **upmchealthplan.com/providers.** Resources include cards that inform Members and their support person of interpretation services available and "I Speak" cards for Members requiring language assistance. Members can hand these cards to office staff upon arrival to inform them of their preferred language.

The interpreter cards and signage-can be ordered for print on Provider OnLine. Go to **upmchealthplan.com/providers** and log in to Provider OnLine.

UPMC providers can also find a list of UPMC Interpretation Resources on the Infonet by searching under "Interpretation." They can also search the Infonet by "Patient Facing Signage." A list of all the interpretation resources and documents for UPMC providers can be found at **upmchs.sharepoint.com/sites/infonet/ClinicalTool/PatientInteractions/Documents/Interpretation_Resources.pdf.**

- Participate in UPMC Health Plan data collection initiatives, such as HEDIS and other contractual or regulatory programs.

Closer Look at Electronic Clinical Data Delivery

UPMC Health Plan reserves the right to obtain ongoing access to data, charts and medical record information related to UPMC Health Plan Members. The provider or provider group is required to allow UPMC Health Plan ongoing access to this information to comply with state, federal, and NCQA clinical, risk, and quality reporting requirements.

As of January 2020, the Pennsylvania Department of Human Services (DHS) is beginning the transition to electronic (digital) clinical quality measures and requires managed care organizations to submit using the electronic quality data. To meet this DHS requirement, when the provider or the provider group has electronic clinical data, UPMC Health Plan offers a broad range of options to deliver this information. UPMC Health Plan's preference is for the providers to join and participate in a state Health Information Organization (HIO). When joining a HIO, the providers need to contribute the data elements on a Continuity of Care Document (CCD) or a Quality Reporting Document Architecture (QRDA) file that would contribute to quality rates. The goal is to increase standardization and decrease the ongoing administrative burden for providers and UPMC Health Plan.

If a provider opts out of participating in a Pennsylvania HIO and submitting QRDA or CCD file elements needed, UPMC Health Plan reserves the right to access electronic clinical data through other file transfer methods (including but not limited to direct EMR/clinical integration via HL7, Clinical Document architecture [CDA], or flat file transfer). In the situation that electronic data access is unavailable, the provider cannot opt out of granting UPMC Health Plan access to the data. UPMC Health Plan staff will work with providers to obtain the data by other methods, such as visiting the provider's office and performing a manual review of records to obtain the needed information.

Additional information on how to choose a HIO can be obtained by accessing DHS' website at **dhs.pa.gov/providers/Providers/Pages/Health Information Technology/Choose-your-HIO.aspx.**

- Collect coinsurance, deductibles, or copayments in full for services rendered.

  ➢ **Note**: **Exception** – If a UPMC Community HealthChoices Participant or a UPMC *for You* Member is **unable to pay** the copayment at the time of the service, the provider **must** provide the service and then bill the Participant or Member for the copayment.

  ➢ **Note: Exception** – Exceptions **may** apply to Special Needs Plan (HMO D-SNP) plan Members.

  ➢ **Note: Exception** – Recognize Medicare-eligible Qualified Medicare Beneficiary (QMB) Members and **do not** attempt to collect (balance bill) for the deductible, coinsurance, or copayments.

  ➢ **See:** ***Restrictions on Member Cost-Sharing and the Grace Period*** for detailed information. UPMC Health Plan Provider Manual:
  - Chapter B, Standards and Procedures
  - Chapter M, UPMC *for Life* Complete Care (HMO D-SNP)

Restrictions on Member Cost-Sharing and the Grace Period

A coinsurance, copayments, or an annual deductible **may** apply to some UPMC *for Life* Complete Care (HMO D-SNP) plan services. Providers **may** submit any unpaid balance remaining, after UPMC Health Plan payments, to the appropriate State source (i.e., Pennsylvania Medical Assistance) for payment consideration.

However, providers **may not** attempt to collect coinsurance, copayments, or deductibles (other than permitted Medical Assistance copayments) from Members for any services provided during the Member's enrollment in UPMC *for Life* Complete Care and Medical Assistance.

➢ **Note:** Federal law prohibits Medicare providers from attempting to collect the, coinsurance, copayments, deductible from a Qualified Medicare Beneficiary (QMB) for Medicare-covered services under any circumstances.

➢ **See:** Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997 for additional information on QMB cost-sharing protections.

If the Member loses their Medical Assistance eligibility, they also lose their special needs status. UPMC *for Life* Complete Care plan will continue to pay for covered services for doctors, hospital, and other providers for a limited time. This is referred to as the **"Grace Period."**

During the Grace Period providers **may bill** the Member for any coinsurance, copayment, or deductible that would have been previously paid by their Medical Assistance coverage.

If a Member **does not** regain their special needs status by the end of the Grace Period and **has not** enrolled in a different Medicare Advantage plan, they will be disenrolled from UPMC *for Life* Complete Care and will be covered by Original Medicare.

Alert—QMB Exception

During this time, all QMB cost-sharing protections and balance billing guidelines continue to apply. The Qualified Medicare Beneficiary (QMB) program provides Medicare coverage of Part A and Part B premiums and cost sharing to low-income Medicare beneficiaries. Federal law prohibits Medicare providers and suppliers, including pharmacies, from attempting to collect coinsurance, copayments, or deductibles from a QMB Beneficiary for Medicare-covered services under any circumstances. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

➢ **See:** ***Section 1902(n)(3)(B) of the Social Security Act,*** as modified by Section 4714 of the Balanced Budget Act of 1997 for additional information on QMB cost-sharing protections.

Therefore, providers **should** verify Member eligibility before they perform a service. Providers **may** verify Member information through Provider OnLine at **upmchealthplan.com/providers** or they **may** call UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

➢ **See:** ***Identifying Members and Verifying Eligibility***, UPMC Health Plan Provider Manual, Chapter I, Member Administration.

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

UPMC *for Life* (Medicare) and UPMC *for Life* Complete Care (HMO D-SNP) providers also have the responsibility to:

- Provide care to the Member within a reasonable period after request for care.

UPMC Community HealthChoices and UPMC *for You* providers (PCPs and specialists) also have the responsibility to:

- To submit UPMC *for You* and UPMC Community HealthChoices claims to the Members' primary insurance first if the Member has other insurance that would be primary to Medical Assistance. Medical Assistance is the payer of last resort. The remaining balance can be submitted to the Member's appropriate plan, either UPMC Community HealthChoices or UPMC *for You*, for payment consideration. Providers are **not** permitted to balance bill the Member for the difference between the provider's change and UPMC Health Plan's allowed amount.

- Provide care to Members in accordance with the required appointment standards and waiting time frames established by the Department of Human Services (DHS). A UPMC Community HealthChoices and a UPMC *for You* Member's average office waiting time for an appointment for routine care is **no more than 30 minutes** or at any time **no more than up to one hour** when the physician encounters an unanticipated urgent medical condition visit or is treating a patient with a difficult medical need.

- Assure Members that if they exercise their Medical Assistance Member rights regarding their care, it will **not** affect the way they are treated by their UPMC Community HealthChoices or UPMC *for You* provider.

- Contact new Members identified in lists provided by UPMC Community HealthChoices and UPMC *for You* who have not had an encounter during the **first six months** of enrollment, or who **have not** complied with established scheduling requirements. Provider shall document the reasons for noncompliance, where possible, as well as efforts to bring the Member's care into compliance.

- **Not** discriminate against Members on the basis of creed, sex, ancestry, marital status, sexual orientation, gender identity, MA status, language, program participation, income status, disease or pre-existing condition or anticipated need for health care.

- Provide care to Medical Assistance recipients during the period from their initial Medical Assistance eligibility determination to the effective date with UPMC Community HealthChoices and UPMC *for You*. This is referred to as the Fee-for-Service (FFS) Eligibility window. Medical Assistance enrolled providers are **prohibited** from denying medically necessary services to the newly eligible Medical Assistance recipient during their FFS window. Providers **must** use the Member's ACCESS or EBT card to access DHS' EVS and to verify the Member's eligibility until the Member/Participant receives an ID card from UPMC Community HealthChoices or UPMC *for You*. The ACCESS or EBT card will allow the provider the capability to access the most current eligibility information without contacting UPMC Community HealthChoices or UPMC *for You* directly. The provider will bill FFS during this time period. UPMC Community HealthChoices Participants **may not** have an ACCESS or EBT card for medical services. Providers **must** still use the DHS' EVS to verify Participant's eligibility using the Participant number on the UPMC Community HealthChoices card.

  ➢ **See:** ***Medical Assistance bulletin #99-13-05,*** effective February 2013.

- **Not charge** Medical Assistance Members for missed appointments (no-shows).

  ➢ **See:** ***Medical Assistance bulletin #99-10-14,*** effective December 2010.

- Notify UPMC Community HealthChoices or UPMC *for You* if the provider has reason to believe a Member is misusing or abusing services or is defrauding a government health care program and/or UPMC Community HealthChoices and UPMC *for You*.

- Communicate effectively with Members, including those with communication barriers and **not** require family members to be used to interpret. Providers **must** arrange for an interpreter for Members who **do not** speak English or who communicate through American Sign Language or other forms of visional/gestural communication. The **Enhanced Member Supports Unit (EMSU)** at **1-866-463-1462,** Monday through Friday from 8 a.m. to 6 p.m., can help participating providers find a translator who can communicate with Members during their appointments.

  ➢ **See:** ***Closer Look at Communicating Effectively*** and ***Closer Look* at *Interpreters and Cost,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

- Communicate with UPMC Community HealthChoices, UPMC *for You*, and other providers regarding identified special needs of Members.

- Observe DHS' guidelines regarding standards of care, including the EPSDT and the Healthy Beginnings Plus programs.

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

- **Not** use any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.

- Participate **annually** in **at least one** UPMC Health Plan-sponsored education session.

- Provide primary and preventive care and act as the Member's advocate, providing, recommending, and arranging for care.

- Identify, appropriately refer, and coordinate mental health, drug and alcohol, and substance abuse services.

- Document all care rendered, including any specialty or referral services, in a complete and accurate medical record and service record that meets or exceeds the Department of Human Services' specification.

- Maintain continuity of each Member's health care.

- Refer Members for needed specialty care and other medically necessary services, both in-network and out-of-network. Obtain prior authorization for out-of-network care.

  ➢ **See:** ***When to contact Utilization Management*****, UPMC Health Plan Provider Manual, Chapter G,** Utilization Management and Medical Management, for information about out-of-network referral prior authorization requests.

Provider Role in: ADA Compliance

Providers' offices are considered places of public accommodation and, therefore, **must** be accessible to individuals with disabilities. Providers' offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504 of the Rehabilitation Act of 1973, and other applicable laws. Providers **may** contact **Provider Services** at **1-866-918-1595** to obtain copies of these documents and other related resources.

UPMC Health Plan requires that network providers' offices or facilities comply with this act. The office or facility **must** be architecturally accessible to individuals with mobility impairments (e.g., wheelchair-accessible) or have provisions to accommodate individuals in wheelchairs. This also refers to parking (if any), path of travel to an entrance, entrance to the building and the provider's office. Patient restrooms should be equipped with grab bars. Handicapped parking **must** be available near the provider's office and be clearly marked. A UPMC Health Plan representative will determine compliance during an onsite office/facility review by conducting an ADA accessibility survey. Providers will receive feedback describing areas requiring modifications, if applicable, to meet the ADA guidelines. Providers will have an opportunity to submit information on how they will address the issues **within 180 days or six months.**

Provider Role in: Compliance

UPMC Health Plan **must** comply with various laws, regulations, and accreditation standards in order to operate as a licensed health insurer. In order to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending, UPMC Health Plan established its distinct Corporate Compliance and Ethics Program.

UPMC Health Plan's Corporate Compliance and Ethics Program serves to assist contracted providers, staff members, management, and the Board of Directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

Reporting Compliance Concerns and/or Issues

UPMC Health Plan has established a Help Line for contracted providers, staff members, and other entities to report compliance concerns and/or issues without fear of retribution or retaliation. The **Help Line** number is **1-877-983-8442,** and it is available **24 hours a day, 7 days a week.** Callers **may** remain anonymous. Compliance concerns include, but are **not** limited to, issues related to compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Gramm-Leach-Bliley Act, and the Americans with Disabilities Act (ADA).

Responsibilities of the provider regarding compliance:

- All UPMC Health Plan contracted providers are expected to conduct themselves according to UPMC Health Plan's Code of Conduct & Ethics.
- All UPMC Health Plan contracted providers have a duty to ***immediately*** report any compliance concerns and/or issues.
- All UPMC Health Plan contracted providers should be alert to possible violations of the law, regulations, and/or accreditation standards, as well as to any other type of unethical behavior.
- UPMC Health Plan prohibits retaliation against contracted providers who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior.
- UPMC Health Plan prohibits retaliation against contracted providers who participate in an investigation or provide information relating to an alleged violation.

The success of UPMC Health Plan's Corporate Compliance and Ethics Program relies in part upon the actions taken by our contracted providers. It is critical for our contracted providers to be aware of the goals and objectives of the UPMC Health Plan Corporate Compliance and Ethics Program, as well as of their responsibilities as providers.

For any questions regarding UPMC Health Plan's Corporate Compliance and Ethics Program and/or a contracted provider's responsibilities, providers **should** contact the **Senior Vice President Chief Risk and Compliance Officer,** at **412-454-8066** or the **Associate Vice President of Corporate Compliance**, at **412-454-5204.**

Provider Role in: HIPAA Privacy & Gramm-Leach-Bliley Act Regulations

Hospitals and providers subject to HIPAA **must** be trained to understand their responsibilities under these privacy regulations. Under HIPAA providers are **required** to give their patients a Notice of Privacy. UPMC Health Plan also provides its Members a Notice of Privacy. UPMC Health Plan's privacy statement and Notice of Privacy Practices are separate and distinct from the Notice of Privacy Practices that providers are required to give their patients.

Provider Role in: Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide behavioral health and substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage. UPMC Health Plan takes compliance with MHPAEA very seriously. For questions or concerns related to MHPAEA or MHPAEA compliance, contact the **Chief Compliance Officer** at **412-454-8066**, or the **Associate VP of Corporate Compliance & Ethics** at **412-454-5204.**

Provider Role in: Reporting Fraud, Waste, and Abuse to UPMC Health Plan

UPMC Health Plan has established a hotline to report suspected fraud, waste, and abuse (FWA) committed by any entity providing services to Members. The hotline number is **1-866-FRAUD-01 (1-866-372-8301) (TTY: 711),** and it is available **24 hours a day, 7 days a week.** Voicemail is available at all times. Callers **may** remain anonymous and **may** leave a voicemail message if they prefer.

> ➢ **Note:** To report suspected fraud and abuse related to UPMC Community HealthChoices call **UPMC Community HealthChoices FWA line** at **1-844-881-4143 (TTY: 711).**

The following are some common examples of fraud and abuse:

- Billing for services and/or medical equipment that were never provided to the Member
- Billing more than once for the same service
- Billing or charging the Member for services paid for by UPMC Health Plan
- Dispensing generic drugs and billing for brand-name drugs
- Offering a prescription or prescription medications without seeing or treating the Member
- Offering gift(s), a prescription(s) or prescription medication(s), or money to Members in exchange for receiving treatment(s) or service(s)
- Falsifying records
- Performing and/or billing for inappropriate or unnecessary services
- Trading prescription drugs for sexual favors

Suspected fraud, waste, and abuse may also be reported via the website at **upmchealthplan.com** or the information may be emailed to **specialinvestigationsunit@upmc.edu.** If reporting fraud, waste, and abuse by mail, mark the outside of the envelope **"confidential" or "personal"** and send to:

UPMC Health Plan
Special Investigations Unit
Personal & Confidential (Do not open in mailroom)
PO Box 2968
Pittsburgh, PA 15230

Information reported by the website, by email, or by regular mail may be done anonymously. The website contains additional information on reporting fraud and abuse.

Reporting Fraud, Waste, and Abuse to the Centers for Medicare and Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to Medicare beneficiaries. The hotline number is **1-800-HHS-TIPS (1-800-447-8477),** and it is available Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voicemail if they prefer.

Reporting Fraud, Waste, and Abuse to the Department of Human Services

The Department of Human Services (DHS) has established a Medical Assistance (MA) Provider Compliance Hotline to report suspected fraud, waste, and abuse committed by any person or entity providing services to Medical Assistance recipients. The **MA Provider Compliance Hotline** number is **1-866-379-8477** and operates Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Providers **may** also call the **Office of Inspector General Welfare Fraud Tip Line** at **1-800-932-0582** to report suspected fraud and abuse committed by a Medical Assistance recipient, such as Members who knowingly make false statements or representations to become eligible for Medical Assistance or Members who fail to provide all required information such as other insurance coverage. Members who commit fraud **may** be prosecuted under state criminal laws and federal fraud and abuse laws.

The following are some common examples of recipient fraud, waste, and abuse:

- Forging or altering prescriptions or orders
- Using multiple ID cards
- A Member loaning their ID card
- Reselling items received through the program
- Intentionally receiving excessive drugs, services, or supplies

Suspected fraud, waste and abuse may also be reported via the Office of Medical Assistance Program's website at **dhs.pa.gov/about/Fraud-And-Abuse.** Information reported by the website or email also **may** be done anonymously. The website contains a MA Provider Compliance Hotline response form and additional information on reporting fraud, waste, and abuse. Suspected fraud, waste, and abuse of services may also be reported by writing to the **Bureau of Program Integrity (BPI)** at the following address:

Department of Human Services
Office of Administration
Bureau of Program Integrity
PO Box 2675
Harrisburg, PA 17105-2675

DHS encourages providers to implement necessary policies, processes, and procedures to ensure compliance with federal and state laws, regulations, and policies relating to the Medical Assistance (MA) Program. As part of these policies and procedures, DHS recommends that providers conduct periodic audits to identify instances where services were reimbursed inappropriately.

DHS established a **Self-Audit Protocol** that provides guidance to providers on the preferred methodology to return inappropriate payments. It encourages voluntary disclosure and communicates DHS' commitment to openness and cooperation. DHS' Self-Audit Protocol is intended to facilitate the resolution of matters that, in the provider's reasonable assessment, potentially violate state administrative law, regulation, or policy governing the Medical Assistance Program, or matters exclusively involving overpayments or errors that **do not** suggest violations of law.

The Self-Audit Protocol can be found on DHS' website at **dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx.**

Providers have several options for conducting self-audits and expediting the return of inappropriate payments to the Department:

- Perform **100 percent** claim review
- Provider-developed Audit Work plan for BPI approval
- DHS pre-approved Audit Work Plan with Statistically Valid Random Sample (SVRS)

If the provider identifies services that were inappropriately paid, they should promptly contact BPI to expedite the return of the inappropriate payment. When the provider properly identifies and reports to DHS inappropriate payments that are **not** fraudulent, DHS **will not** seek double damages but will accept repayment without penalty. Penalties would normally range from **not less than $13,508** and **not more than $27,018 per false claim, plus three times the amount of any other damages** the U.S. government sustains because of the fraudulent claims.

> ➢ **Note**: The False Claims Act penalty amounts are subject to change. The amounts may increase **each year** with inflation.

The False Claims Act (31 U.S.C. sub sec 3729) makes it illegal to present or cause to be presented to the federal or state government a false or fraudulent claim for payment. This applies to U.S. government programs such as Medicaid, Medicare, Medicare Part D, the Federal Employees Health Benefit Plan (FEHB) and Postal Services Employees Health Benefit (PSHB). Any person in violation of this act could be subjected to fines and penalties.

Providers that have questions regarding this protocol may contact **BPI** at **717-772-1079** to discuss this protocol with the Provider Self-Audit Protocol Coordinator.

Provider Role in: Surveys and Assessments

UPMC Health Plan conducts a series of surveys and assessments of Members and providers in a continuous effort to improve performance. All providers are urged to participate when asked. UPMC Health Plan retains responsibility for monitoring provider actions for compliance with federal and state requirements.

Provider Standards and Requirements

Office Hours

Network Primary Care Providers (PCPs) **must** have **a minimum of 20 office hours** per week. In addition, they **must** be available for access **24 hours a day, 7 days a week, 365 days a year.** The office **may** have an after-hours monitoring answering service or paging system that will allow Members to either speak to the provider or leave a message/phone number for a call-back.

Verifying Provider Practice Information

The network management staff will verify important demographic information about a practice each time a staff member makes a service call. This verification is needed to ensure accuracy in various areas that concern providers, including claims payments and provider directories.

Maintaining accurate and up-to-date provider information for Members is critical. The Centers for Medicare & Medicaid Services (CMS), Department of Human Services (DHS), and Pennsylvania Insurance Department (PID) all require UPMC Health Plan to maintain a current and accurate provider directory. It is the responsibility of participating providers to ensure that their practice information is accurate in UPMC Health Plan's Provider Directory. Participating providers are required to notify UPMC Health Plan immediately of changes to their practice. In addition, the provider directory information **must** be reviewed and updated quarterly, even if there are no practice changes.

Information can be viewed by searching the online directory for the provider's name at **upmchealthplan.com/find.**

Information can be updated at **upmchealthplan.com/providers/change.html.**

➢ **Note:** The following information **must** be continually reviewed and updated:

- Ability to accept new patients
- Street address
- Phone number
- Office hours
- Hospital privileges
- Any other information that affects the provider's availability to the Member

Failure to comply with this requirement may lead to provider sanctions and termination.

Alert—Product Termination

UPMC Health Plan requires notification of product termination in writing **60 calendar days** before the change to avoid improper claims payment and incorrect provider directory information.

Providers **should** notify UPMC Health Plan of any provider additions, practice changes, or corrections within **60 business days**. The following changes **may** be made through an online request form at **upmchealthplan.com/providers/change.html.**

- Addition/Deletion of a provider to/from a practice
- Addition or removal of an office location
- Changes to such information as phone/fax numbers, office hours, and hospital privileges
- Change in billing address or tax identification number
- Changes to product participation
- Provider terminations from the network

If the online form **cannot** be completed the following forms **may** be printed and mailed to UPMC Health Plan.

- Add or Remove Provider
- Add or Remove Office Location
- Office or Provider Information Change
- Change Pay to Address or Tax ID
- Change in Hospital Privileges
- Close/Reopen Panel
- Add/Drop Products
- Physician Termination

Provider **may also** notify UPMC Health Plan by mailing the information in a letter. The notification **must** be typewritten and submitted on business letterhead and **must** include the following information:

- Physician name
- Office address
- Billing address (if different than office address)
- Phone number and fax number
- Office hours
- Effective date
- W-9 tax form

Mail all provider changes to **Provider Data Maintenance** at:

UPMC Health Plan
Provider Data Maintenance
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

Voluntarily Leaving the Network

Providers **must** give UPMC Health Plan **at least 90 calendar days** written notice before voluntarily leaving the network. In order for a termination to be considered valid, providers are required to send termination notices by c**ertified mail (return receipt requested) or overnight courier.** In addition, providers **must** supply copies of medical records to the Member's new provider and facilitate the Member's transfer of care **at no charge** to the Member or UPMC Health Plan.

UPMC Health Plan
Provider Data Maintenance
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

UPMC Health Plan **will notify** affected Members in writing of a provider's termination, and how to request continuing care, if applicable. If the terminating provider is a primary care provider (PCP), UPMC Health Plan will request that the Member select a new PCP. If a Member **does not** select a PCP prior to the provider's termination date, UPMC Health Plan will automatically assign one.

Alert — Notifying Affected Members

UPMC Community HealthChoices will send a letter to affected Participants a**t least 45 days prior** to the provider's termination.

UPMC *for You* will send a letter to affected Members **within 30 days** of receipt of the provider's written notice of termination.

Providers **must** continue to render covered services to Members who are existing patients and are in an ongoing and an active course of treatment of a medical condition at the time of termination. This allows sufficient time for the Member to arrange for continued care. Pregnant Members undergoing a course of treatment for the pregnancy can request transition of care through the postpartum period.

The transition of care period may be up to either **60 to 90 calendar days** depending on the Members' plan**,** or until UPMC Health Plan can arrange for appropriate health care for the Member with a participating provider, **whichever is greater.**

UPMC Health Plan will reimburse the provider for the provision of covered services up to the applicable number of **calendar days** from the termination date. This includes reimbursement for the provision of covered services to Members who are pregnant and undergoing a course of treatment for the pregnancy through the postpartum period.

The transition of care period **may** be extended after consultation with the Member and provider, if determined to be clinically appropriate.

An ongoing course of treatment is defined as the Member receiving care from a provider during the previous **12 months,** the enrollee was treated by the provider for a condition that requires follow-up care or additional treatment, or the services have been prior authorized.

Exceptions **may include:**

- Members requiring only routine monitoring.
- Providers unwilling to continue to treat the Member.
- Providers unwilling to accept UPMC Health Plan payment and meet the same terms and conditions of participating providers.

Product	Transition Period	Clinically appropriate Extension Permitted	Pregnant Members
CHIP	Up to **60 days**	Yes	2nd – 3rd trimester, through postpartum period
Commercial	Up to **90 calendar days**	Yes	Through postpartum period
Community HealthChoices (Medical Assistance)	Up to **60 days**	Yes	Any trimester through postpartum period
Health Choices (Medical Assistance)	Up to **60 days**	Yes	Any trimester Through postpartum period
Medicare	**90 days**	Yes	Any trimester Through postpartum period
HMO D-SNP	**90 days**	Yes	Any trimester Through postpartum period

➢ **Note:** If UPMC Health Plan terminates the contract of a participating provider for cause (breach of contract, fraud, etc.); UPMC Health Plan is **not** responsible for coverage of services provided to the Member by the terminated provider following the effective date of termination. UPMC Health Plan works with the Member to find an in-network provider to provide the Member's care.

Coverage for Providers on Vacation or Leave

While on vacation or leave of **less than 30 calendar days,** a network provider **must** arrange for coverage by another UPMC Health Plan participating provider. If a provider goes on an extended leave for **30 calendar days or longer,** the provider **must** notify **Provider Services** at the appropriate number listed below**:**

UPMC Behavioral Health Services (BHS)	**1-866-441-4185**
UPMC Community HealthChoices (Medical Assistance)	**1-844-860-9303**
UPMC *for Kids* (CHIP)	**1-866-918-1595**
UPMC *for Life* (Medicare)	**1-866-918-1595**
UPMC *for Life* Complete Care (HMO D-SNP)	**1-866-918-1595**
UPMC *for You* (Medical Assistance)	**1-866-918-1595**
UPMC Health Plan (Commercial, including FEHB and PSHB)	**1-866-918-1595**

Locum Tenens Billing Arrangements

Substitute providers are often necessary to cover professional practices when the regular providers are absent for reasons such as illness, pregnancy, vacation, or continuing education. The regular provider should bill and receive payment for the substitute provider's services as though these services were performed by the regular provider.

The regular provider **may** submit the claim and receive payment in the following circumstances:

- The substitute provider **does not** render services to patients over a continuous period of longer than **60 calendar days.**

- The regular provider identifies the services as substitute provider services by entering a **Q6 modifier** (services furnished by a locum tenens provider) after the procedure code.

Alert—An Example of Locum Tenens Billing

The regular provider goes on vacation on June 30 and returns to work on Sept. 4. A substitute provider renders services to patients of the regular provider on July 2 and at various times, thereafter, including Aug. 30 and Sept. 2. The continuous period of covered services begins on July 2 and runs through Sept. 2, a period of **63 calendar days.**

Since the Sept. 2 services were furnished after a period of **60 calendar days** of continuous service, the regular provider is not entitled to bill and receive direct payment for these services. The substitute provider **must** bill for these services in their own name. The regular provider may, however, bill and receive payment for the services that the substitute provider rendered on the regular provider's behalf during the period from July 2 through Aug. 30.

24-Hour On-Call Coverage

PCPs and ob-gyns are **required** to provide **24-hour on-call coverage** and be available **7 days a week, 365 days a year.** If a provider delegates this responsibility, the covering provider **must** participate in UPMC Health Plan's network and be available **24 hours a day, 7 days a week, 365 days a year.**

Provider Scope of Services

Providers **may** bill UPMC Health Plan for all services performed for assigned Members. The services **should** be within the scope of standard practices appropriate to the provider's license, education, and board certification.

Provider Effective Date

The effective date for provider participation is the date that UPMC Health Plan Credentialing Committee approves the application.

For Specialists: In-Office Procedures

Specialists should perform procedures only within the scope of their license, education, board certification, experience, and training. UPMC Health Plan will periodically evaluate the appropriateness and medical necessity of in-office procedures.

In-Office X-Ray

A licensed radiology technician may perform in-office radiology services. The American College of Radiology **must** certify radiology facilities. A radiologist **must** review all x-rays.

In-Office Laboratory

Offices that perform laboratory services **must** meet all regulatory guidelines, including, but not limited to, participation in a Proficiency Testing Program and certification by the Clinical Laboratory Improvement Amendments (CLIA).

Guidelines Regarding Advance Directives

An advance directive is generally a written statement that an individual composes in advance of serious illness regarding medical decisions affecting them. The **two** most common forms of advance directives are a living will and a durable health care power of attorney. All adults have the right to create advance directives. In the event that an individual is unable to communicate the kind of treatment they want or **do not** want, this directive informs the provider, in advance, about that individuals' treatment desires.

A Living Will

A Living Will takes effect while the individual is still living. It is a signed, witnessed written document concerning the kind of medical care that individual **wants** or **does not** want and are unable to make a decision about care.

A Durable Health Care Power of Attorney

A durable health care power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if the individual is unable to do so. A durable health care power of attorney can include instructions about any treatment the individual desires to undergo or avoid. Neither document becomes effective until the individual is unable to make decisions. The individual can change or revoke either document at any time. Otherwise, the documents remain effective throughout the individual's life.

Closer Look at Advance Directives

If a provider is unable to honor an advance directive, the individual may transfer to the care of a provider willing to carry out the Member's wishes, as appropriate to their benefit plan.

Legislative Basis for Advance Directives

The requirements for advance directives are outlined in the **Omnibus Budget Reconciliation Act of 1990**, which went into effect on Dec. 1, 1991. If a Member decides to execute a living will or a durable health care power of attorney, the Member is encouraged to notify their PCP of its existence, provide a copy of the document to be included in personal medical records, and discuss this decision with the PCP.

For more information about advance directives, contact:

The Pennsylvania Medical Society
Division of Communication and Public Affairs
77 East Park Drive
Harrisburg, PA 17105-8820
717-558-7750

Closer Look at the Legislation

Hospitals and other health care providers that participate in the Medicare Advantage and Medical Assistance programs **must** provide Members with written information about their right to make their own health care decisions, including the right to accept or refuse medical treatment and the right to execute advance directives.

Guidelines for Medical Record Documentation

UPMC Health Plan requires participating network physicians to maintain Member medical records in a manner that is accurate and timely, well-organized, readily accessible by authorized personnel, and confidential. Per UPMC Health Plan policy, all medical records **must** be retained for **10 years.**

Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care.

UPMC Health Plan has adopted certain standards for medical record documentation, which are designed to promote efficient and effective treatment. UPMC Health Plan periodically reviews medical records to ensure that they comply with the guidelines below.

➢ **See: Table B.1, *Medical Record Documentation Guidelines*, for how performance is evaluated.**

Table B1: Medical Record Documentation Guidelines

Category	Score	Action
Level 1:	Pass = 10 or more points including Required Element*	Compliant – **No** follow-up required
Level 2:	Fail = 0 to 9 points	Requires a corrective action plan and follow-up review in **six months**
Level 3:	Fail = Automatic fail if missing Required Element*	Requires a corrective action plan and a follow-up review in **three months**
Required Element = Organization and secure storage of medical records		

Basic Information

- Place the Member's name or ID number on each page of the medical record.
- Include marital status and address, name of employer, and home and work telephone numbers.
- Include the author's identification in all entries in the medical record. The author identification may be a handwritten signature, a unique electronic identifier, or their initials, (e.g., progress notes need to include the signature and credentials of the provider of service).
- Date all entries.
- Ensure that the record is legible to someone other than the writer.

Medical History

- Indicate significant illnesses and medical conditions on the problem list. If the patient has no known medical illnesses or conditions, the medical record should include a flow sheet for health maintenance.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, providers should appropriately note this in the record.
- Document in an easily identifiable manner family, social, and past medical history, which **may** include serious accidents, operations, and illnesses. For children and adolescents **18 years old and younger,** past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For Members **14 years old and older,** note the use of cigarettes, alcohol, substances, and query substance abuse history.

- Physicians **should** indicate that they reviewed the history forms completed by staff. Review by and signature of another professional, such as a nurse practitioner or physician assistant, **does not** meet this requirement.
- Maintain an updated immunization record for patients **18 years old and younger.**
- Include a record of preventive screenings and services in accordance with the UPMC Health Plan Preventive Health Guidelines.
- Include, when applicable, summaries of emergency care, hospital admissions, surgical procedures, and reports on any excised tissue.

Treatment

- Document clinical evaluation and findings for each visit. Identify appropriate subjective and objective information in the history and physical exam that is pertinent to the Member's complaints.
- Document progress notes, treatment plans, and any changes in a treatment plan, including drugs prescribed.
- Document prescriptions telephoned to a pharmacist.
- Document ancillary services and diagnostic tests that are ordered and diagnostic and therapeutic services for which a Member was referred.
- Address unresolved problems from previous office visits in subsequent visits.
- Document the use of Developmental Delay and Autism Spectrum Disorder screening tools.
- Document referrals to **CONNECT** for Medical Assistance children **younger than 5 years old,** if developmental delays are suspected and the child **is not** receiving **CONNECT** services at the time of screening.

Follow-Up

- Include on encounter forms or within the notes a notation regarding follow-up care, calls, or visits. Providers **should** note the specific time of recommended return visit in weeks, months, or as needed.
- Keep documentation of follow-up for any missed appointments or no-shows.
- Physicians **should** initial consultation, lab, imaging, and other reports to signify review. Review by and signature of another professional, such as a nurse practitioner or physician assistant, **does not** meet this requirement.
- Consultation, abnormal lab, and imaging study results **must** have an explicit notation of follow-up plans in the record.

Closer Look at Children's Health Insurance Program Product (UPMC *for Kids*) and Medical Assistance Products (UPMC Community HealthChoices and UPMC *for You*) Outreach Requirements

PCPs, dentists, and specialists should conduct affirmative outreach whenever a Member misses an appointment and document the outreach in the medical record. Such an effort shall be deemed to be reasonable if it includes **three attempts** to contact the Member. **At least one** attempt **must** be a follow-up phone call.

Such attempts may include, but are **not limited to:**

- Written attempts.
- Phone calls.
- Home visits.

UPMC Community HealthChoices Participants with LTSS, their PCPs, dentists, and specialists **may** request that a Participant's Service Coordinator conduct outreach. The Service Coordinators will evaluate any barriers to the Participant's attendance at appointments and develop any necessary plan to facilitate and improve the Participant compliance with the appointment scheduled.

Providers **may not** charge CHIP Members for missed appointments.

Medical Assistance Members **may not** be charged for appointments (no-shows) per **Medical Assistance Bulletin #99-10-14.**

Medical Record Confidentiality and Security

- Store medical records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only.
- Periodically train medical office staff and consistently communicate the importance of medical record confidentiality.

Medical Record Documentation Cloning

Documentation from a Member's previous visit(s) that is copied (cut and paste) or pulled from the electronic medical record (EMR) to auto-populate the medical record is called Cloning. Documentation that is the same from Member to Member is also Cloning. The medical record documentation for the visit **must** accurately reflect the Member's condition, treatment, and supporting medical necessity. Cloning could cause incorrect information to be placed in the medical record. Documentation that **does not** support the service provided would be cause for UPMC Health Plan to deny the service, recoup payments, and review as a false claim.

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

Accessibility Standards

UPMC Health Plan follows accessibility requirements set forth by applicable regulatory and accrediting agencies. UPMC Health Plan monitors compliance with these standards annually.

Table B2: Accessibility Requirements

Type of Appointment	Scheduling Time Frame
Primary Care Providers	
Emergency	**Immediately**, or refer to the emergency room
Non-Urgent Sick Visit	Within **72 hours** of the request (as clinically indicated)
Preventive Care	Within **3 weeks** of the request
Regular and Routine	Within **10 business days** of the request
Urgent	Within **24 hours** of the request
Obstetrician-Gynecologists	
Annual Well-Woman Exam	Within **3 weeks** of the request
Prenatal Care	
First Trimester	Within **10 business days** of the request
Second Trimester	Within **5 business days** of the request
Third Trimester	Within **4 business days** of the request
High Risk	Within **24 hours** of identification of high risk to a maternity care provider, or immediately, if an emergency exists
Emergency	**Immediately,** or refer to the emergency room
Specialists	
Emergency	**Immediately,** or refer to the emergency room
Routine Care .	Within **10 business days** of the request. ➢ **Except** for the following specialty providers, who **must** be scheduled within **15 business days** of the request: • Dentist • Dermatology • Otolaryngology • Orthopedic Surgery
Urgent Care	Within **24 hours** of the request

Table B2: Accessibility Requirements, cont'd

Type of Appointment	Scheduling Time Frame
Specialists, cont'd	
Routine Care	Within **10 business days** of the request. ➢ **Except** for the following specialty providers, who **must** be scheduled **within 15 business days** of the request: • Pediatric Allergy & Immunology • Pediatric Dentistry • Pediatric Endocrinology • Pediatric Gastroenterology • Pediatric General Surgery • Pediatric Hematology • Pediatric Infectious Disease • Pediatric Nephrology • Pediatric Neurology • Pediatric Oncology • Pediatric Pulmonology • Pediatric Rehab Medicine • Pediatric Rheumatology • Pediatric Urology

Alert—Scheduling UPMC Community HealthChoices Participants or UPMC *for You* Members Who Have AIDS or Are HIV-Positive

Primary care providers and specialists also have the responsibility to maintain adequate scheduling procedures to ensure an appointment is scheduled **within seven days** from the effective date of enrollment for any UPMC Community HealthChoices Participant or UPMC *for You* Member known to be HIV-positive or diagnosed with AIDS, unless the Member is already in active care with a PCP or specialist.

Emergency Services

In case of a medical emergency, the Member **should** attempt to call their PCP, if possible, explain the symptoms, and provide any other information necessary to help determine appropriate action.

The Member **should** go to the nearest emergency facility for the following situations:

- If directed by the PCP
- If the Member **cannot** reach the PCP or the covering provider
- If the Member believes they have an emergency medical condition

Members with an emergency medical condition should understand they have the right to summon emergency help by calling **911** or any other emergency telephone number, as well as a licensed ambulance service, **without** getting prior approval.

UPMC Health Plan will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Closer Look at Emergency Care

Emergency services **do not** require prior authorization. The hospital or facility **must** contact **Utilization Management** through **Provider OnLine** at **upmchealthplan.com/providers** on the **next business day or within 48 hours** after the emergency admission.

Urgent Care

Urgent care is defined as any illness, injury, or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated **within a 24-hour period** and, if left untreated, could rapidly become an emergency medical condition.

When in UPMC Health Plan's primary service area, Members should contact their PCPs if they have an urgent medical need. UPMC Health Plan encourages providers to make **same-day** appointments available for their patients who call with unscheduled urgent health care needs. This improves the quality and continuity of patient care.

If Members are unable to contact their PCPs, and they believe they need care immediately, they should seek immediate medical attention. After such treatment, Members should contact their PCPs within a reasonable amount of time. A reasonable amount of time is typically considered **24 hours** unless there are extenuating circumstances.

Alert—Urgent Out-of-Area Care

If outside of UPMC Health Plan's primary service areas, Members should seek medical attention immediately if they believe they need urgent care. Members should then call their PCPs, who, in turn, **must** contact **Utilization Management** by the **next business day** to ensure the claim is paid at the appropriate level. A request can be submitted through **Provider OnLine** at **upmchealthplan.com/providers.** If approved, UPMC Health Plan will give the provider a confirmation number. The PCP should note this number in the Member's records.

➢ **See:** ***Out-of-Area Care,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedure.

Out-of-Area Care

Out-of-area care **should not** be confused with out-of-network care. Out-of-area care is care rendered to Members traveling outside UPMC Health Plan's primary service area. Out-of-network care is care sought by Members at a facility or provider **not within** the network appropriate to the Member's benefit plan.

➢ **See:** ***Alert—Out-of-Network Referrals,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

All UPMC Health Plan Members are covered for emergency care when they travel outside the UPMC Health Plan network.

- **For UPMC Community HealthChoices Participants,**

➢ **See:** ***Out-of-Area Care,*** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices.

- **For UPMC *for You* Members,**

➢ **See:** ***Out-of-Area Care,*** UPMC Health Plan Provider Manual, Chapter E, UPMC *for You*.

Alert – Temporary Closed Panel Notification

Providers can inform UPMC Health Plan Network that they **are not** able to accommodate new patients for a temporary period by completing a Panel Changes request form found online at **upmchealthplan.com/providers/change.html** and checking the **"Close or Reopen Panel"** box. If the online form **cannot** be completed, it may be printed and mailed or emailed to UPMC Health Plan. This information will then be posted in UPMC Health Plan's web-based searchable provider directory. The information will be updated when the provider notifies UPMC Health Plan that they are able to meet access standards.

➢ See: ***Table B.3,*** Temporary Closed Panel Notification Contacts.

Table B.3

Temporary Closed Panel Notification Contacts	
Mail to:	**UPMC Health Plan** **Network Development and Provider Data Maintenance Department** **U.S. Steel Tower, 37th Floor** **600 Grant Street** **Pittsburgh, PA 15219**
Email for:	
Medical Providers	**providernetworkinquiries@upmc.edu**
Dental Providers	**hpdental@upmc.edu**
Vision Providers	**hpvision@upmc.edu**

Routine Care

Members **must** seek routine and preventive care from providers within their network. Utilization Management will review extenuating circumstances. Providers **may** contact Utilization Management through **Provider OnLine** at **upmchealthplan.com/providers.**

Injury or Illness

A Member who needs care while traveling outside the service area **should** contact their PCP, if applicable**, within 24 hours,** or as soon as reasonably possible, to inform the PCP of the nature of the illness or injury. The PCP **must** submit a request through **Provider OnLine** at **upmchealthplan.com/providers** to obtain authorization for services rendered by a nonparticipating provider. If Utilization Management authorizes the care, the level of benefits will be determined at that time. UPMC Health Plan (Commercial) Members who receive a bill or have paid for services provided outside the area should submit those bills to UPMC Health Plan, using an Out-of-Network Care claim form. An Out-of-Network Care claim form is included in the UPMC Health Plan (Commercial) Member's information packet, or the Member can download a form at **upmchealthplan.com.** The Member **also may** call the **UPMC Health Plan Health Care Concierge team** at **1-888-876-2756 (TTY: 711),** Monday through Friday from 8 a.m. to 6 p.m..

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Travel Assistance Program

Through a travel assistance program, UPMC *for Life* (Medicare), UPMC *for Life* Complete Care (HMO D-SNP), and UPMC Health Plan (Commercial) Members have access to pre-qualified medical providers when they have a medical emergency and are **more than 100 miles** from home. Members **should** call their Health Care Concierge team to receive information about their travel assistance benefit.

The travel assistance program will provide a list of reliable doctors and/or safe medical facilities and direct the Member to the closest, most appropriate medical facility, and will notify UPMC Health Plan accordingly.

At **no charge** to the Member, the travel assistance program will coordinate various services, which include, but are **not limited to,** the following:

- Medical referrals
- Medically supervised transportation to the Member's home
- Transportation of a family member to join the Member
- Emergency medical evacuation
- Care for minor children
- Critical care monitoring
- Dispatch of prescription medicine
- Emergency message transmission
- Hospital admission guarantee
- Return of mortal remains

> ➢ **Note: Member's obligation –** The Member still needs to call their PCP, if applicable, but the PCP **does no**t need to call Utilization Management as long as the Member uses the travel assistance program.

Referrals and Coordination of Care

Provider Role in Coordinating Care

UPMC Health Plan relies on each provider to ensure the appropriate use of resources by delivering quality care in the proper setting at the right time. UPMC Health Plan's approach to accountability is based on the belief that providers know what is best for UPMC Health Plan Members. UPMC Health Plan relies on our providers to:

- Provide the appropriate level of care.
- Maintain high quality.
- Use health care resources efficiently.

Closer Look at Referrals

Providers **are required** to coordinate a Member's care with other specialists, behavioral health providers, therapists, hospitals, laboratories, and facilities in the network appropriate to the Member's benefit plan.

In addition, providers **are required** to refer Members to other Participating Providers (including **but not** limited to specialists, behavioral health providers, hospitals, laboratories and facilities). Use of network providers helps Members maximize medical benefits and reduce out-of-pocket expenses.

Failure to comply with this requirement **may** lead to provider termination. Network providers are responsible for determining the type of care the Member needs and the appropriate provider or facility to administer that care.

UPMC Health Plan **does not require a referral form,** but providers **must** follow a referral and coordination process to ensure high-quality care and accurate reimbursement for services.

The Role of the Referring Provider

Coordination of care requires that providers communicate with specialists, behavioral health providers, therapists, and other providers regarding the Member's care. In turn, those providers **should** reciprocate by informing the referring provider of their findings and proposed treatment. This sharing of information can be accomplished by telephone, fax, letter, or prescription. Providers also need to supply UPMC Health Plan with critical information needed to authorize certain types of care and process claims.

For UPMC Community HealthChoices Participants with LTSS, providers **should** also communicate with Participant's Home and Community Based Services (HCBS) providers and service coordinators. HCBS services are authorized through the Participant's person-centered service plan, and it is important that providers work closely with Participant's service coordinators and HCBS providers to understand the Participant's needs.

Providers should follow these steps when referring a Member to a specialist:

1. **Direct specialty care to providers, therapists, laboratories, and/or hospitals appropriate to the Member's benefit plan.**
   The only time a provider should send a Member to specialists, therapists, laboratories, and hospitals outside the Member's benefit plan is when extenuating circumstances require the use of an out-of-network specialist or facility or because the only available specialist or facility is not part of the Member's benefit plan. The provider **must** have prior authorization from **Utilization Management** to refer a Member to an out-of-network specialist or facility.

   ➢ **See:** ***Alert—Out-of-Network Referrals,*** UPMC Health Provider Manual, Chapter B Provider Standards and Procedures.

2. **Correspond with the specialist/behavioral health provider.**
   The provider **may** call or send a letter, fax, or prescription to the specialist. The referring provider should communicate clinical information directly to the specialist without involving the Member.

3. **Give the facility, specialist, or behavioral health provider the following referral information:**
   - Member's name
   - Reason for the referral
   - All relevant medical information (e.g., medical records, test results)
   - Referring provider's name and Unique Provider Identification Number (UPIN) or National Provider Identifier (NPI) (This information is required in **boxes 17 and 17A** on the CMS-1500 claim form.)

     ➢ **See:** ***Required Fields on a CMS-1500 Claim form*****,** UPMC Health Plan Provider Manual, Chapter H, Claims Procedures.

     ➢ **See:** ***UPMC Health Plan provider directory,*** which is available online at **upmchealthplan.com.** For a printed copy call **Provider Services** at:

UPMC Behavioral Health Services (BHS)	**1-866-441-4185**
UPMC Community HealthChoices (Medical Assistance)	**1-844-860-9303**
UPMC *for Kids* (CHIP)	**1-866-918-1595**
UPMC *for Life* (Medicare)	**1-866-918-1595**
UPMC *for Life* Complete Care (HMO D-SNP)	**1-866-918-1595**
UPMC *for You (*Medical Assistance)	**1-866-918-1595**
UPMC Health Plan (Commercial, including FEHB, PSHB)	**1-866-918-1595**

Alert—Out-of-Network Referrals

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

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

Alert—Referrals required for the Healthcare Exchange

UPMC Health Plan offers several products that utilize a referral-based benefit design. These plans require a referral when seeking services with a specialist. The words "Referral Required" will be printed on the front of the Member's ID card. The primary care physician is required to enter the referral utilizing UPMC Health Plan's secure portal, Provider OnLine. The portal allows the physician to enter the referral for a specific physician, practice, or specialty for up to **90 calendar days** as a "Consult" or "Consult and Treat." The referral is valid as of the date entered and **90 calendar days** forward. There are **no** retroactive referrals. The specialty office has the ability to log into Provider OnLine to verify that a referral has been entered. The provider **must** log into the secure portion of Provider OnLine to access the referral inquiry. Begin the process to obtain a log-in and password by accessing the following link: **upmchealthplan.upmc.com/WebPortals/Requests/SecurityRequest.aspx.**

To obtain assistance with the login and password process contact **Provider Services** at **1-800-937-0438** from 8 a.m. to 5 p.m., Monday through Friday.

- **Note:** A referral is **not required** for pediatric Members **younger than age 21.** In addition, a referral **is not required** for those Members seeking care for chemotherapy, ob-gyn preventive services or services from a pediatric specialist, or a behavioral health professional.

- **Note:** This referral process only applies to individuals who purchased a certain UPMC Health Plan coverage through the **Healthcare Exchange (Pennie)**. The referral process **does not apply** to the following plans: UPMC Community HealthChoices (Medical Assistance), UPMC *for Kids* (CHIP), UPMC *for Life (*Medicare), UPMC *for Life* Complete Care (HMO D-SNP), UPMC *for You (*Medical Assistance), and UPMC Health Plan (Commercial).

The Role of the Specialist for UPMC Health Plan (Commercial), UPMC *for Life* (Medicare), or Medicare Select

1. **Verify whether the care was coordinated.**
   When a Member sees a specialist, the specialist's office needs to determine whether a provider coordinated the care, or the Member directly accessed the specialist for care. (If care was coordinated, the PCP's name and UPIN are required in **boxes 17 and 17A** on the CMS-1500 claim form.)

   ➢ **See:** ***Required Fields on a CMS-1500 Claim Form,*** UPMC Health Plan Provider Manual, Chapter H, Claims Procedures.

   If a provider coordinated the care …
   … collect any paperwork or check office records for communication from the referring doctor.

   If the Member self-directed care to a specialist …
   … contact the PCP, if applicable, to obtain medical records and check to see if any diagnostic testing already has been completed to avoid duplicate testing.

   If the Member does not have a PCP …
   … obtain a medical history and try to determine whether any prior diagnostic testing has been performed.

2. **Determine the copayment.**
   If the visit is self-directed by a Member whose benefit plan ***does not*** *require the selection of a PCP …*
   … care is covered at a higher benefit level if the Member uses a network provider and at a lower benefit level if the Member uses an out-of-network provider.

3. **Communicate findings.**
   The specialist **must** communicate findings and treatment plans to the referring provider **within 30 calendar days** from the date of the visit. The referring provider and specialist should jointly determine how care is to proceed.

Closer Look at Referrals by Specialists

A specialist **may** coordinate the patient's care with another specialist as long as network providers are used. The specialist providing the care is responsible for communicating pertinent findings to the Member's PCP, when applicable, and for submitting the referring specialist's name and UPIN or NPI on the claim.

➢ **See:** ***Required Fields on a CMS-1500 Claim Form,*** UPMC Health Plan Provider Manual, Chapter H, Claims Procedures.

The Role of the Specialist for Medical Assistance (UPMC Community HealthChoices and UPMC *for You*)

1. **Verify that the PCP coordinated the care.**
   When a Member sees a specialist, the specialist's office needs to determine that the Member's PCP or ob-gyn coordinated the care. If there is no communication from the PCP or ob-gyn and the medical condition requires immediate treatment, the specialist **should** call the PCP or ob-gyn. (If care was coordinated, the PCP's name and UPIN are required in **boxes 17 and 17A** on the CMS-1500 claim form.)

2. **Provide services indicated by the referral.**
   The specialist can provide only those services that are indicated by the referral. If the Member needs other services, the specialist **must** contact the PCP or ob-gyn. The PCP may approve an ongoing "standing" referral to a specialist in some cases. Members **may** also request a specialist to be their PCP by contacting the UPMC Health Plan Health Care Concierge team.

   ➢ **See:** ***Selecting a Specialist as a Member's PCP and Standing Referrals,*** UPMC Health Plan Provider Manual, Chapter I, Member Administration.

3. **Communicate findings.**
   The specialist **should** communicate findings and a treatment plan to the Member's PCP. The PCP and specialist **should** then jointly determine how care should proceed, including when the Member **should** return to the PCP's care.

Alert—Referrals by Specialists to Other Specialists

Specialists **cannot** refer Members directly to other specialists. If the Member needs to see another specialist, the specialist **must** contact the Member's PCP or ob-gyn to discuss the need for a referral.

Alert—Out-of-Network Referrals by Specialists

Specialists **cannot** make out-of-network referrals. If a specialist believes an out-of-network referral is necessary, the specialist **must** contact the Member's PCP or ob-gyn. If a UPMC Community HealthChoices Participant or a UPMC *for You* Member requires a referral to out-of-network specialists and facilities, an authorization **must** be obtained from **Utilization Management** by submitting a prior authorization request through **Provider OnLine** at **upmchealthplan.com/providers.** The requesting provider **must** give the reason for the out-of-network referral. If written information is required, it may be sent to:

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

Referrals for Ancillary Services for UPMC Community HealthChoices and UPMC *for You*

UPMC Community HealthChoices and UPMC *for You* providers are required to coordinate referrals for ancillary services.

➢ **See:** ***Services Descriptions*****,** UPMC Health Plan Provider Manual, Chapter N, UPMC Community HealthChoices.

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

When referring a UPMC Community HealthChoices Participant or a UPMC *for You* Member for ancillary services, the PCP **must** follow these steps:

1. **Obtain prior authorization from Utilization Management, if applicable.**
   Providers **should** obtain prior authorization for out-of-network ancillary referrals or for ancillary services from **Utilization Management** by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers** and entering the authorization request.

2. **Communicate with the ancillary provider.**
   After verifying eligibility, providers **should** send a letter or fax, or write a prescription for equipment and/or services.

Closer Look at Medical Records for Coordination of Care and Referrals

Providers **shall** maintain an individual medical record for each UPMC Health Plan Member in accordance with applicable state and federal laws and regulations, customary medical practice, and UPMC Health Plan policies and procedures.

Providers agree that UPMC Health Plan's Members **shall** have access to their medical records **at no charge** and upon request. In the event that a Member disenrolls from UPMC Health Plan or transfers to a new participating provider/practitioner, the provider/practitioner **shall** cooperate in the transfer of all applicable medical records and information to the new provider/practitioner **without charge** to the Member.

Hospital Guidelines

At a Glance

UPMC Health Plan urges all providers to use the services of a network hospital. This will reduce costs, both to UPMC Health Plan and to Members, and ensure Members receive the highest quality care.

Providers who want to use out-of-network hospitals for nonemergencies **must** receive prior authorization from **Utilization Management** by submitting an authorization request through **Provider OnLine** at **upmchealthplan.com/providers.** The requesting provider **must** give the reason for the out-of-network referral. If written information is required, it **may** be sent to:

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

Observation Status

Observation status applies to Members for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when:

- The Member's condition is expected to be evaluated and/or treated **within 24 hours,** with follow-up care provided on an outpatient basis.
- The Member's condition or diagnosis is not sufficiently clear to allow the Member to leave the hospital.

Closer Look at Observation Status

If a Member in observation status is admitted, authorization is required. Contact **Utilization Management** at **1-800-425-7800** at the time of service regarding the need to admit. If after hours, leave a message and a representative will follow up the **next business day.**

Network Hospitals

- **Inpatient Admissions**
  Network providers **may** admit a Member to any network hospital appropriate to the Member's benefit plan. If the admitting provider is a specialist, the specialist **must** communicate the admission to the Member's PCP, if applicable, to ensure continuity and quality of care.

- **Emergency Admission**
  Upon admitting a Member from the emergency department, the hospital **should** collect the following information:
  - The practice name of the Member's PCP, if applicable
  - The name of the Member's referring provider if referred for emergency care
  - The name of the admitting provider if different from the referring provider or PCP

  The hospital or facility **must** notify **Utilization Management** through **Provider OnLine** at **upmchealthplan.com/providers** **within 48 hours** or on the **next business day** following the emergency admission.

- **Elective Admission**
  To admit a UPMC Community HealthChoices Participant or a UPMC *for You* Member for an elective admission, the admitting provider **must** obtain prior authorization at least **seven business days** prior to the admission by submitting a request through **Provider OnLine** at **upmchealthplan.com/providers.** The admitting provider **must** work with the hospital to schedule the admission and any pre-admission testing.

Out-of-Network Hospitals

- **Emergencies**
  When a Member is admitted to an out-of-network hospital for an emergency medical condition, the provider **must** contact **Utilization Management** at **1-800-425-7800** and ask to speak to a medical review nurse. The nurse may coordinate a transfer to a hospital appropriate to the Member's benefit plan when the Member is medically stable.

- **Nonemergencies**
  Members **should not** be admitted to out-of-network hospitals unless prior authorization is obtained from Utilization Management for medically necessary services not available in the network. Providers **must** contact Utilization Management by submitting a prior authorization request through **Provider OnLine** at **upmchealthplan.com/providers.**

- **Inpatient Consultation and Referral Process**
  If the admitting provider determines that a Member requires consultation with a specialist, the admitting provider **must** refer the Member to a network specialist appropriate to the Member's benefit plan. The referral should follow the hospital's locally approved procedures (e.g., consultation form, physician order form, etc.). The admitting provider and specialist jointly should determine how care should proceed. Coordination of care occurs through active communication among the PCP, the admitting provider, and the specialist.

Pre-Admission Diagnostic Testing

All pre-admission diagnostic testing conducted before a Member's medically necessary surgery or admission to the hospital is covered when performed at a hospital appropriate to the Member's benefit plan. Some procedures **may** require prior authorization.

If testing is completed **within 72 hours** of the Member's admission, it is included with the admission. Otherwise, the testing can be billed separately.

Pre-admission diagnostic testing includes:

- Laboratory diagnostic tests.
- Radiological diagnostic tests.
- Other diagnostic tests, including electrocardiogram, pulmonary function, and neurological.

Transfers

Transfers Between Network Facilities

If a Member is admitted to a network hospital and needs to be transferred to another hospital, UPMC Health Plan requires that the Member be sent to a hospital appropriate to the Member's benefit plan. The transferring provider **must** coordinate the transfer with a representative at the receiving facility.

Providers **must** contact **UPMC Medical Transportation** at **1-877-521-RIDE (7433)** to arrange any type of transportation.

Transfers to Out-of-Network Facilities

UPMC Health Plan requires prior authorization for transfer to an out-of-network facility. The transferring provider **must** contact **Utilization Management** at **1-800-425-7800** and speak to a medical review nurse or submit a request through **Provider OnLine** at **upmchealthplan.com/providers.** Without prior approval, coverage will be denied.

Closer Look at Coordinating Transfers

Urgent and routine medical transportation **must** be provided by a network ambulance service. To coordinate transportation, providers **must** contact **UPMC Medical Transportation** at **1-877-521-RIDE (7433).**

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

Discharges

Utilization Management works with the hospital's Utilization Management Department to coordinate discharge planning.

A discharge planner is available to assist in coordinating follow-up care, ancillary services, and other appropriate services. Contact **Utilization Management** at **1-800-425-7800** to speak to a discharge planner.

Hospital Delivery Notification

The hospital in which a UPMC *for You* newborn is delivered **must** fill out a **Hospital Maternity Profile form** and fax it to the **Medical Assistance Program** at **412-454-5731.**

For copies of the Hospital Maternity Profile form, providers **should** call **Provider Services**, at **1-866-918-1595.**

Additionally, as contracted Medical Assistance providers, hospitals and birthing centers maintain the responsibility of notifying (via fax or phone) the County Assistance Offices (CAO) **immediately** after the birth, then following up by mailing the **MA-112 (Newborn Eligibility Form)** to the applicable CAO **within three business days of the birth.** Additional copies of the form **may** be obtained by contacting the Pennsylvania Department of Human Services.

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

Provider Disputes

There are several ways that a provider can dispute a decision by UPMC Health Plan to deny or reduce coverage of care or services. The easiest ways with the fastest response to dispute those decisions is by a phone call to **Provider Services** at **1-866-918-1595,** or through the use of online chat or a web message. Then, if the dispute **has not** been resolved to the satisfaction of the provider, the provider has the right to submit a formal appeal, in writing.

Appeals fall into **two categories: administrative (nonmedical necessity) and medical necessity.** A medical necessity appeal can be standard priority or expedited. Appeals are reviewed by UPMC Health Plan and assigned to the appropriate committee based on the nature of the appeal.

> ➢ **Note**: When using the term "appeals" related to a Member, "appeal" refers to the Member's Appeal or Complaint and Grievance process.

If the provider initiates an appeal on behalf of a Member, with the written consent from the Member, as evidenced by documentation that comports with Pennsylvania law, the appeal is managed through the Member Complaint/Grievance/Appeal process, which includes expedited requests.

> ➢ **See:** ***Initiating an Appeal on Behalf of the Member,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures for full details.

Resubmitting a corrected claim due to minor error or omission **is not** an appeal. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address, as submitting as an appeal **could** delay the processing of the corrected claim unnecessarily.

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

Closer Look - Appeals must be submitted within 30 business days of the initial denial

A request for an administrative or a medical necessity appeal **must** be submitted in writing by mail or email **within 30 business days** of the initial denial notification. The denial notification **may** be a denial letter, audit finding letter, or an Explanation of Payment (EOP) relevant to the issue being appealed. With the exception of audit appeals, multiple Members **may not** be submitted on **one** request.

> ➢ **Note:** The EOP can be viewed **24 hours a day, 7 days** a week by accessing **Provider OnLine** at **upmchealthplan.com/providers.**

Alert – Submission of Complete and Relevant Documents

The request **must** include the reason for the appeal and a copy of the **complete, relevant** medical record and all other relevant supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal, and include the date(s) of services being appealed.

If the documentation sent to support the appeal is insufficient for UPMC Health Plan to accurately render an appeal decision, the appeal **may** be withdrawn and a response letter will be sent to the provider without a decision. The provider **may** re-submit the appeal with additional information, but timely filing standards will apply. The use of the UPMC Health Plan cover sheet is highly recommended. The cover sheet can be found at **upmchealthplan.com/providers/medical/resources/forms.**

For additional information or questions about the right to appeal or how to file an appeal, providers may call **Provider Services** at **1-866-918-1595,** from 8 a.m. to 5 p.m., Monday through Friday**.**

Administrative Appeal – (nonmedical necessity)

Administrative appeals involve claims or authorization requests that have been denied for reasons other than a determination that the service at issue **was not** medically necessary. An Administrative appeal **does not** have a prior Medical Director (MD) review.

Some examples are:

- The care **was not** coordinated with the PCP
- Prior authorization was required **but not** obtained
- Untimely claim submission
- UPMC Health Plan has determined that the service at issue is experimental or investigational

The following outlines the Administrative Appeal process:

1. **Provider sends a written appeal to UPMC Health Plan.**
   Within 30 business days of the initial denial, the provider sends a written appeal by U.S. mail or email to UPMC Health Plan at the following mail or email address as below, stating the reason the claim was denied (from the Explanation of Payment) and includes **any and all** supporting documentation as to why the provider believes the decision should be reversed. With the exception of audit appeals, multiple Members **may not** be submitted on **one** request.

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

   Email: HPtempproviderappeal@upmc.edu

➢ **Note:** For appeals submitted by email

- All relevant information **must** be attached to the email.
- If more than **one** email is required due to the size of attachments the subject line and the body **must** include notification that there are multiple emails for one appeal. For example: Part 1 of 3, Part 2 of 3, and Part 3 of 3.
- For the submission of appeals that contain a large number of pages of medical records or supporting documentation, it is highly recommended to use the Provider Appeals PO box and **not** email.

2. **Committee reviews the denial.**
   A committee of **one or more** UPMC Health Plan employees reviews administrative appeals and renders a decision. The committee reviews such appeals only **once.**

3. **Committee makes a decision.**
   The committee renders a decision within **60 business days** of the receipt of the appeal. **All decisions are final.** A letter will be sent to the provider for all appeal decisions **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. If the decision is reversed the provider also receives notification of the decision of the review by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers.** Provider OnLine is available **24 hours a day, 7 days a week.**

The following outlines the Medical Necessity Appeal Process

Appeals in which a provider formally communicates in writing, a request for reconsideration of a denial decision that was based on the medical necessity or appropriateness of a service. There are **two levels** of appeal available to providers regarding denials based on medical necessity.

➢ **See:** ***Glossary of Health Care Terms***, UPMC Health Plan Provider Manual, Chapter K, Glossary and Abbreviations, for the definitions of medical necessity by product.

First Level Medical Necessity Appeal - Medical Services

1. **Provider sends a written appeal to UPMC Health Plan.**
   Within 30 business days of the initial denial notification, the provider sends a written appeal by mail or email to UPMC Health Plan to the following mail or email address as below:

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

   Email: HPtempproviderappeal@upmc.edu

➢ **Note:** For appeals submitted by email:

- All relevant information **must** be attached to the email.
- If **more than one** email is required, due to the size of attachments, the subject line and the body **must** include notification that there are multiple emails for one appeal. For example: Part 1 of 3, Part 2 of 3, and Part 3 of 3.
- **Requests for an expedited appeal cannot be sent by email or mail.**
- For the submission of appeals that contain a large number of pages of medical records or supporting documentation it is highly recommended to use the Provider Appeals PO box **and not by** email.

The request **must** include the reason for the appeal and a copy of the complete, relevant medical record and all other relevant supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal and include the date(s) of service being appealed.

2. **Provider/Practitioner reviews the appeal.**
   A provider/practitioner of the same/similar specialty of care that is being appealed, who **was not** involved with the initial determination, reviews the dispute.

3. **Committee makes a decision.**
   A Committee comprised of UPMC Health Plan staff and a provider/practitioner, reviews the dispute and a decision is rendered **within 30 business days**.

4. **Provider receives notification of the decision.**
   A letter will be sent to the provider for all appeal decisions **within 10 business days** of the decision. If the medical necessity denial is overturned (reversed) the claim is adjusted **within 30 business days** of the date of the decision. When the decision is reversed, the provider also receives notification of the decision telephonically and/or by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers.** Provider OnLine is available **24 hours a day, 7 days a week.**

Expedited Medical Necessity Appeal – Medical Services

The provider can request an expedited medical necessity review when:

- The provider/practitioner disagrees with a decision to deny a service, approve at a lesser level or duration than requested or approved an alternative service; and
- The denial decision was based on medical necessity and appropriateness; and
- The denial involved urgent or concurrent care and in the opinion of the provider, a delay of the services poses an imminent and serious threat to the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The request for an expedited appeal **must** also include a completed Expedited Medical Necessity Appeal Request Form, which can be found at **upmchealthplan.com/providers/medical/resources/forms/medical-pa.aspx.**

A UPMC Health Plan Physician will review the Expedited Medical Necessity Appeal Request Form to properly determine, in accordance with UPMC Health Plan policies and procedures, the need for the appeal process to be worked as expedited. If the UPMC Health Plan Physician reviewer determines that in accordance with UPMC Health Plan's policies and procedures the expedited request **does not** meet expedited criteria, a letter will be sent to the provider **within two business days,** and the appeal will be worked as standard priority.

A request for an expedited medical necessity appeal must be faxed to 412-454-7920. The request **must** include the reason for the appeal and a copy of the medical records and other supporting documentation.

Medical Necessity Appeal process – Pharmacy Services

1. **Provider sends a written appeal to UPMC Health Plan**.
   Within 30 business days of the initial denial notification, the provider sends a written appeal by mail or email to UPMC Health Plan to the following mail or email address as below:

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

   Email: HPtempproviderappeal@upmc.edu

   ➢ **Note:** For appeals submitted by email

   - All relevant information **must** be attached to the email.
   - If **more than one** email is required due to the size of attachments the subject line and the body **must** include notification that there are multiple emails for one appeal. For example: Part 1 of 3, Part 2 of 3, and Part 3 of 3.
   - Requests for an expedited appeal **cannot** be sent by email or mail.
   - For the submission of appeals that contain a large number of pages of medical records or supporting documentation it is highly recommended to use the Provider Appeals PO box and **not by email.**

   The request **must** include the reason for the appeal and a copy of the complete, relevant medical record and all other relevant supporting documentation. The request for appeal should clearly state why and on what basis the provider wishes to appeal and include the medication being appealed.

2. **Provider/Practitioner reviews the appeal.**
   A provider/practitioner of the same/similar specialty of care that is being appealed, who was **not** involved with the initial determination, reviews the dispute.

3. **Committee makes a decision.**
   A Committee comprised of UPMC Health Plan Pharmacist and a provider/practitioner, reviews the dispute and a decision is rendered **within 30 business days**.

4. **Provider receives notification of the decision.**
   A letter will be sent to the provider for all appeal decisions **within 10 business days** of the decision. If the medical necessity denial is overturned (reversed) the claim is adjusted **within 30 business days** of the date of the decision. When the decision is reversed, the provider also receives notification of the decision telephonically and/or by way of the Explanation of Payment (EOP) for the claim. The EOP can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers.** Provider OnLine is available **24 hours a day, 7 days a week.**

Expedited Medical Necessity Appeals – Pharmacy Services

The UPMC Health Plan Expedited Provider Appeal Certification Form **must** be used for the request and **must** be signed by the provider. The form can be found under **Resources and Information** at **upmchealthplan.com/providers/medical/resources/forms/medical-pa.aspx.**

If the provider fails to submit a signed certification with the request, then UPMC Health Plan will decide the appeal within the standard appeal time frames. After the request with the accompanying certification is received with the signed UPMC Health Plan Expedited Provider Appeal Certification Form, a decision is rendered as quickly as is warranted by the Member's condition **but no later than 48 hours** after the request is received.

A request for an expedited medical necessity appeal **must** be faxed to **412-454-7920.** The request **must** include the reason for the appeal, the Expedited Provider Appeal Certification Form and a copy of the complete, relevant medical record and all other relevant supporting documentation.

For additional information or questions about how to file an expedited medical necessity appeal contact **Provider Services** at **1-866-918-1595.** Monday through Friday from 8 a.m. to 5 p.m.

Closer Look at Medical and Pharmacy Expedited Appeals

. The provider receives verbal confirmation of the Expedited Review decision **within 48 hours.** Written confirmation is sent to the provider **within two business days** of the verbal notification of the decision.

Upheld – The written notification of the denial includes the reason for the denial.

Overturned – Any appropriate authorizations are added to the Utilization Management system.

Initiating an Appeal on Behalf of the Member

If the provider initiates an appeal on behalf of a Member, with written consent from the Member or the Member's personal designated representative, the appeal is managed through the Member Complaint/Grievances/Appeals process, which includes Expedited Appeals. Written consent **is not required** for Medicare *Advantage* or Medicare Special Needs Plan Members as long as the appeal is made on behalf of the Member by the physician and on the physician's letterhead.

- The provider **may** ask the Member for their written consent to pursue an appeal at the time of treatment or service—but **not** as a condition of providing that treatment or service.
- An appeal of an adverse decision filed by a provider with written consent from the Member or the Member's personal designated representative is processed as a Member appeal and **not** a provider appeal. When providers file on behalf of a Member they have the **same time frames** as the Member in which to file.
- The provider **may not** bill the Member for services that are the subject of the appeal until the review has been completed or the Member's consent has been rescinded.
- The Member **cannot** file a separate appeal for the same denied treatment or service. If a Member wishes to do so, the Member **must** first rescind consent to the provider.
- The Member retains the rights to rescind the consent at any time during the grievance process, and the Member **may** continue with the grievance at the point at which the consent was rescinded.
- If the provider obtained consent to file an appeal and decides **not** to file on the Member's behalf the provider **must** notify the Member or the Member's legal representative **within 10 days** from receipt of the standard written utilization review denial and any decision letter from a medical necessity appeal.
- The Member's consent is automatically rescinded if the provider fails to file a grievance.

Member's written consent guidelines

If a Member requests that a provider file an appeal, the Member **must** complete a consent form or write a letter. The consent form or letter of consent **must** include certain information, statements, and signatures that are required by the Pennsylvania Department of Health **(28 Pa. Code § 9.706).** If the appeal request **does not** contain all the necessary requirements the appeal will be processed as a provider appeal and follow the standard provider time frames. Providers can obtain a complaint consent form on the UPMC Health Plan website at **embed.widencdn.net/pdf/plus/upmc/fkrst1jlmq/19PV994741---Provider-Appeal-on-Behalf-of-Member-WEB.pdf?u=oid6pr** or by contacting **UPMC Health Plan's Provider Services Department** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

> ➢ **Note**: Filing time frames vary by product and the type of appeal, e.g., Complaint, Grievance, Appeal, Expedited, or External.

➢ **See:** ***UPMC Health Plan Provider Manual chapters*** for Member Appeal, Complaints, and Grievances procedures.

Chapter	UPMC Health Plan Products
Chapter C	UPMC Health Plan (Commercial, including FEHB and PSHB)
Chapter D	UPMC *for Kids* (CHIP)
Chapter E	UPMC *for You* (Medical Assistance)
Chapter F	UPMC *for Life* (Medicare)
Chapter M	UPMC *for Life* Complete Care (HMO D-SNP)
Chapter N	UPMC Community HealthChoices (Medical Assistance)

➢ **See:** UPMC Health Plan ***Member handbooks or Member guides*** detailing the Member's Complaint and Grievance procedures:

UPMC Health Plan Products	Location
• **Federal Employees Health Benefits (FEHB)**	**upmchealthplan.com/fehb**
• **Federal Postal Service Health Benefits (PSHB)**	**upmchealthplan.com/pshb**
• **UPMC Community Health Choices (Medical Assistance)** • **UPMC *for Kids* (CHIP)** • **UPMC *for Life* (Medicare)** • **UPMC *for Life* Complete Care (HMO D-SNP)** • **UPMC *for You* (Medical Assistance)**	**upmchealthplan.com**
• **UPMC Health Plan (Commercial)**	**upmc.widen.net/s/vps5rkn2ph**

Provider Credentialing

UPMC Health Plan credentials all applicable contracted providers, practitioners, health care professionals, and any other applicable licensed independent practitioners who provide professional care and treatment to UPMC Health Plan Members.

UPMC Health Plan's credentialing program involves both the initial credentialing and the recredentialing of the following types of practitioners:

- Acupuncturists
- Behavioral Health – Doctoral (PhDs) and/or master's level psychologists, master's level social workers, master's level clinical nurse specialist or psychiatric nurse practitioners and other Behavioral Specialists
- Chiropractors (DC)
- Certified Registered Nurse Practitioners (CRNP)
- Certified Nurse Midwives (CNM)
- Dentists (DDS or DMD)
- Oral Surgeons – Includes both Doctors of Dental Medicine (DMD) and dental surgery (DDS)
- Optometrists (OD)
- Primary Care Physicians (PCP) - Includes both Medical Doctor (MD) and Doctor of Osteopathy (DO) physicians
- Physician Extenders - Certified Nurse Anesthetists (CRNA), and Physician Assistants
- Podiatrists (DPM)
- Specialist Physicians – Includes both MDs and DOs

Noncredentialed Professionals

The credentialing and recredentialing process **does not apply** to hospital-based physicians who do not have an independent contract with UPMC Insurance Services Division and who **are not** listed in the Member's directories. These include:

- Anesthesiologists
- Emergency Medicine Room Physicians
- Hospitalists
- Intensivists
- Pathologists
- Radiologists

> ➢ **Note:** Practitioners who have independent contracts and fall into these medical types may be credentialed. Examples include but are **not limited** to a hospitalist who is also contracted as a PCP or a board-certified emergency medicine physician who also works in an Urgent Care Setting.

The following practitioner types, who are not listed in Member directories, may be credentialed on a case-by-case basis.

- Audiologists
- Allied Health Professionals including:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Therapy (ST)

Special Credentialing

In addition to completing the general credentialing application to join the UPMC Health Plan network, providers **may** apply for special credentialing. Decisions on special credentialing applications are based on quality and specialty services provided by the applicant. This includes: Provider and Organizational Provider (Facility).

Specialty	Provider Type
Dual PCP/Specialist	MD or DO
Hip & Knee COE	MD or DO

Organizational Provider (Facility)
CT, PET scans, MRIs
Low-dose CT scans
Hip & Knee COE-Facility

➢ **Note:** Any omissions to requested documentation will cause delays in review/approval for any of the above special credentialing.

Application Process

The provider credentialing process involves several steps:

- Request for network participation
- Application submission
- Primary source verification
- Onsite evaluation (if appropriate)
- A Credentials Committee review
- Provider notification

Application – Initial Credentialing

Providers interested in becoming a UPMC Health Plan provider should submit a network participation request online at **upmchealthplan.com/providers/request.html** or by calling **412-454-5264.** If the request is approved, an application will be sent to the provider. The provider should fill in all the requested information, sign, and date the application, and return it with any requested documents for initial processing to UPMC Health Plan by the following methods:

Email: ProviderNetworkInquiries@upmc.edu

Mail: UPMC Health Plan Network
U.S. Steel Tower, 37th Floor
600 Grant Street
Pittsburgh, PA 15219

Application – Recredentialing

According to UPMC Health Plan guidelines, network providers **must** be recredentialed, at a **maximum** of **every three years** from the date of their initial credentialing. If the provider uses the Council of Affordable Quality Health (CAQH) database, the provider **should** update their information, attest to its accuracy in the (CAQH) database, and give UPMC Health Plan permission to view the information. If CAQH application **is not** an option, the provider **should** fill in all the requested information, sign, and date the application Invite received from Application Manager portal. The provider **should** reply with any requested documents for processing to the Application Manager portal.

➢ **Note:** If the provider is a member of a UPMC Health Plan network Physician Hospital Organization (PHO), Physician Organization (PO), or another entity that UPMC Health Plan works with to credential/recredential providers, the provider should return the completed application to that organization for processing. Providers with questions about where to submit an application can contact **Provider Services** at **1-866-918-1595.**

Closer Look at the Application Process

The Credentialing and Network departments check the application for completeness. If documents or other information is missing, the credentialing staff will contact the provider office for the missing supporting documentation that would allow the credentialing process to move forward. Providers **must** provide a signature reflecting the new date of completion.

Primary Source Verification

The Credentialing Department checks each primary source to verify the following:

- Board certification
- Malpractice insurance coverage and history of liability claims
- Medical Assistance Sanctions
  - List of Excluded Individuals and Entities (LEIE)
  - Medicheck Listing
- Medicare sanctions
- Registration with the Pennsylvania Department of Human Services as a Medicaid provider with a valid PROMISe ID for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You* providers
- Sanctions, restrictions, or suspensions of a state license
- Status of staff privileges at a network UPMC Health Plan hospital(s)
- Valid DEA or CDS certification for each state in which the provider practices
- Valid National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES)
- Valid, unrestricted license to practice in state(s) in which the practice resides
- Work history (This **does not require** primary source verification, although **gaps of six months or greater must** be clarified in writing by the provider for inclusion in the credentialing file.)

➢ **See:** ***Disclosure of Ownership and Control*****,** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

On-Site Evaluation

UPMC Health Plan **may** contact providers to arrange an on-site evaluation of practice site(s) and/or medical record documentation. **At a minimum,** the following UPMC Health Plan standards will be assessed:

- Adequacy of waiting room and exam room space
- Availability of appointments
- Emergency care and CPR certification
- Hazardous waste elimination
- Medical equipment management
- Medical record documentation
- Medication administration
- Physical accessibility, availability, and appearance of practice site(s)
- Radiology, cardiology, and laboratory services (if applicable)

Provider Rights

Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information on the application to the primary source data. If any discrepancies are noted, the provider is notified in writing and has **14 calendar days** to forward the correct information in writing to the UPMC Health Plan Credentialing Department supervisor. The information **must** be sent in writing by mail or by fax from the facility or department from where the information originated (e.g., state license board, education facility, hospital). The Credentialing Department will document the receipt of the additional, corrected information in the provider's credential file. The corrected information will be reviewed by the Credentials Committee.

In addition, a provider has the right to review the information submitted in support of their application. If the provider discovers erroneous information on the application, the provider has the opportunity to correct this information before the Credentials Committee reviews it. The provider **must** initial and date the corrected information and re-sign and date the attestation form. Upon request, a provider also has the right to be informed of the status of their credentialing or recredentialing application. The Credentialing staff will inform the provider of their credentialing status verbally or in writing depending upon the format (written/verbal) of the request submitted by the provider. Providers' rights are documented on the UPMC Health Plan Provider Application. Changes to providers' rights will be communicated to providers in writing.

Credentials Committee Review

Completed credential files are then presented to the Credentials Committee for review and deliberation. A welcome letter and packet are sent to the providers once they are approved as providers in the UPMC Health Plan provider network. Providers will be notified in writing if they are denied credentialing status for any reason. If a provider wishes to appeal a credentialing denial decision, the request **must** be submitted by a letter addressed to the chairperson of the Credentials Committee.

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

Alert—Credentialing Approval

UPMC Health Plan **does not** permit providers to render care to Members prior to credentialing approval for network participation, **except for UPMC *for You* providers.**

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Alert—Network participating approval effective date for UPMC *for You*

Effective Jan. 1, 2024, a UPMC *for You* (Medical Assistance) approved credentialing application will have the provider's application date as their participation effective date in the UPMC *for You* network.

Recredentialing Process

All providers **must** be recredentialed at a **maximum of every three years** from the date of their initial credentialing. The recredentialing process is the same basic process as that for credentialing, except that providers are also evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but not be limited to, the following:

- Compliance with UPMC Health Plan's policies and procedures
- UPMC Health Plan sanctioning related to utilization management, administrative issues, or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality of care activities
- Quality-of-care concerns

Review of the provider CAQH or Application Manager application for recredentialing are started **about six months before** the provider's recredentialing date to enable the credentialing process to be completed within the required period.

Alert—Recredentialing

Failure to return the completed recredentialing application and supporting documentation within the requested time limit **may** result in termination from the network. This is part of the UPMC Health Plan Provider contractual agreement.

Dual Credentialing and Recredentialing as a PCP and Specialist

UPMC Health Plan will consider, as an exception, requests from providers to participate as both a PCP and specialist when the provider:

- Meets UPMC Health Plan credentialing standards for each specialty requested.
- Provides documentation demonstrating adequate professional training, expertise, capacity, and capabilities to undertake such responsibilities for providing both primary care and specialty services.
- Agrees to be listed as a PCP in all Member literature and accept membership.
- Agrees **not to** bill consultation charges for Members enrolled in the PCP practice regardless of the nature of the visit.

Credentialing and Recredentialing Issues

Board Certification

UPMC Health Plan requires that PCPs and specialists be board certified in their respective specialties by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Physician Specialties, the Royal College of Physicians and Surgeons of Canada, or the Royal College of London, or the Australian College of Physicians.

Depending on the availability of qualified, board-certified physicians, the following exceptions may apply:

- Providers who meet all other qualifications but began practicing a specific scope of medical practice before the availability of board certification in their particular specialty. Such providers **must** have active admitting privileges at a UPMC Health Plan-affiliated hospital.
- Providers who are **within five years** of completion of an approved residency or fellowship in the specialty in which they practice.
- Providers who are Members of a group practice in which **50 percent** of the group physicians are board-certified in the requesting provider's specialty.
- Providers who are practicing in federally designated underserved areas and meet all other credentialing standards, including:
    - Practicing in a requested specialty for **more than five years.**
    - Active admitting privileges at a UPMC Health Plan network facility in the appropriate department.

Malpractice Insurance

UPMC Health Plan requires that providers carry professional liability at **no less than** the current Pennsylvania Insurance Department minimum requirements or in accordance with the state requirements in which their practice resides. Providers **must** submit a copy of their current malpractice insurance face sheet with the amount of coverage and policy effective dates at the time of credentialing or recredentialing.

Credentialing Denials and Appeals

UPMC Health Plan will send a letter to a provider who has been denied credentialing. The letter will include appeal rights if applicable. If applicable, the provider **may** appeal a credentialing decision in the following manner:

1. **Provider sends written request to the Credentials Committee chairperson.**
    - Providers **should** send requests for appeals to the following address:

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

2. **The Credentials Committee chairperson sends the provider written notice of the hearing.**

   - The hearing date, time, and place, as well as the composition of the appeals committee, will be sent to the provider **at least 30 calendar days** before the scheduled hearing date. The notice will include a request for the provider's consent to disclose the specifics of their application and all credentialing documentation to be discussed at the hearing.

   - The provider has the right to be present and is allowed to offer evidence or information to explain or refute the cause for denial. Legal counsel also can represent the provider, as long as UPMC Health Plan is informed of such representation **at least seven business days** before the hearing.

3. **The Appeals Committee conducts the hearing and sends recommendation to the Quality Physician Advisory Council (QPAC).**

   - The Appeals Committee, consisting of **three** voting providers selected by the Credentials Committee chairperson, will deliberate without the provider present. Its decision will be by majority vote and will be forwarded to UPMC Health Plan's QPAC as a recommendation.

4. **The QPAC makes a decision and notifies the provider.**

   - The QPAC decision is final. Written notice of the decision will be sent to the provider in an expeditious and appropriate manner and will include a written statement giving the basis of the decision.

Nonphysician Providers, a.k.a. Advanced Practice Providers

The following provider types are often referred to as Nonphysician Providers (NPP), Advance Practice Providers (APP), Mid-Level Providers, or Physician Extenders:

- Certified Clinical Nurse Specialist (CNS)
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Registered Nurse Practitioners (CRNP)
- Physician Assistant (PA)

The following paragraphs provide a brief overview of UPMC Health Plan credentialing and claim submission requirements for these provider types. Providers should be knowledgeable of the various regulatory requirements.

> ➢ **Note:** Within this manual these provider types will be collectively referred to as **NPPs.**

CRNPs acting as PCPs

UPMC Health Plan permits CRNPs to be credentialed as a PCP. They are credentialed and recredentialed using the procedures as described in the previous pages. The CRNP **must** have certification that qualifies for Pennsylvania (or the state in which they practice) licensure. Areas of specialization include **but are not** limited to:

- Adult Health
- Family Health
- Gerontology
- Pediatrics
- Primary Care

Closer look at Primary Care Providers

A primary care provider (PCP) is a health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes, or otherwise provides or proposes to provide health care services to a Member; a PCP provides preventive and routine care in accordance with UPMC Insurance Services Division Standards, initiates Member referral for specialist care and maintains continuity of Member care.

In addition to Initial or Recredentialing requirements the following items are required:

- A copy of their collaborating agreement and a list of names of physicians with whom they have an additional collaborative agreements or documentation as required per state policy
- Documented arrangements for the provision of emergency physician consultation and for emergency treatment and inpatient hospital care
- A copy of the valid certificate for an approved certification (board)

Medical Assistance

NPPs **must** obtain a NPI number, and they **may** enroll in the Medical Assistance program and receive a PROMISe™ ID (also known as MMIS Provider ID). NPPs who render, order, refer, or prescribe items or services to Medical Assistance Members **must** enroll as a participating provider in the Medical Assistance program and become credentialed by UPMC Health Plan. They enroll in the Medical Assistance program by completing and submitting a **provider type 10-Mid Level Practitioner application.** This is required even if the NPPs indicate that they are the rendering provider. The billing of the NPPs services is also dictated based on their employment relationship with the supervising physician.

➢ **Note:** Providers should become familiar with the following NPP regulations:

- The NPPs services are subject to the provisions of PA Code Chapter 1101 and Chapter 1150.
- The Physician and CRNP collaboration agreement related to the CRNP's performance of medical acts as defined in the rules and regulations of the State Board of Nurse Examiners (49 PA Code 21.251 and 49 Pa. Code § 21.282a).
- 55 PA Code, Chapter 1144 Certified Registered Nurse Practitioner Services, Section 1144.53 related to noncompensable services.
- Medical Assistance Bulletin: MAB 01-22-05, 08-22-05, 09-22-04, 10-22-01, 31-22-05, effective January 2022.
- Request for Assignment of Fees form. Located at: **dhs.pa.gov/providers/Providers/Documents/p_023558.pdf**

Certified Registered Nurse Anesthetist

UPMC Health Plan **does not** issue payment directly to CRNAs for Members **21 years old and older.** Payment is made to the network physician directing the CRNA. Payment is made directly to the CRNAs for Members **younger than age 21** as a result of the OBRA 89 (Omnibus Budget Reconciliation Act of 1989) and Medicare cost sharing, since Medicare allows direct payment to CRNAs. CRNAs **must** be enrolled in the MA program with a valid/active PROMISe ID and **must** be credentialed by UPMC Health Plan to receive payment.

Alert—Pennsylvania Medical Assistant recipients with Medicare in a Coordination of Benefits Agreement (COBA) allows for Cost Sharing of Medical Assistance eligible services for Medicare and Medicare Advantage crossover claims. As a result, the Department of Human Services' PROMISe claims processing allows payment of the Cost Sharing amounts when the rendering provider type is either a CRNP or PA for Medical Assistance eligible services for both Medicare and Medicare Advantage claims.

Medicare

NPPs **must** obtain a National Provider Identifier (NPI) and enroll in the Medicare program. The performance of a service and the submission of the claim **may** be provided by the NPP, using their Medicare ID number or billed incident, to a supervising medical service physician. When the NPP is billing under their own ID number as a rendering provider or **may** be ordering or prescribing, they **must** be credentialed by UPMC Health Plan.

Providers **should** become familiar with CMS' NPP regulations, qualifications, and billing guidelines such as **but not limited** to:

- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants, Medicare Learning Network Booklet, April 2020.
- Medicare Claims Processing Manual.
- Medicare Benefit Policy Manual.
- 42 Code of Federal Regulations (CFR).

Commercial/Exchange/CHIP:

NPPs **must** obtain a NPI number and be credentialed by UPMC Health Plan to be permitted to bill as the rendering provider within the scope of their practice, education, training, and state licensing. NPPs who **are not** credentialed would bill as incident to a supervising physician for the PAs or a collaborating physician for the CRNPs. UPMC Health Plan allows coverage for credentialed CRNP/CRNA/PA for covered services, such as maternity care, urgent care visits, behavioral health and substance abuse, home health care, skilled nursing services and services within the scope of their state license. If a NPP is providing services incident to a physician, UPMC Health Plan follows Medicare Incident-to guidelines.

Providers should become familiar with NPP Commercial laws and regulations, and Medicare Incident-to requirements. These laws and regulations include but are not limited to the following:

- PA Statute, Title 63 Professions and Occupations, Chapter 7 Nurses, 63 P.S. §§218.2
- PA Statute, Title 63 Professions and Occupations, Chapter 12 Medical Practice Act, 63 P.S. § 422.13; 63 P.S. § 422.36
- PA Code, Title 49 Professional and Vocational Standards, Chapter 18 State Board of Medicine – Practitioners other than Medical Doctors
- PA Code, Title 49 Professional and Vocational Standards, Chapter 21 State Board of Nursing, §21.17 Anesthesia

➢ **Alert—**UPMC Health Plan processing and payment of services provided by NPPs **may** be subject to change as directed by regulatory agencies during an event of a Public Health Emergency.

➢ **Note:** Providers who see UPMC *for Kids* (CHIP) Members **must** obtain a Medical Assistance PROMISe ID number.

➢ **See:** Provider PROMISe ID Requirements, UPMC Health Plan provider Manual, Chapter B, Provider Standards and Procedures.

Provider PROMISe ID Requirements

All providers who render, order, refer, or prescribe items or services to UPMC Community HealthChoices, UPMC *for Kids*, or UPMC *for You* Members are required to have a valid PROMISe™ ID (also known as MMIS Provider ID) with the Commonwealth of Pennsylvania. PROMISe™ IDs correspond to both the provider and location. Thus, the provider **must** register an ID **for each location at which they provide services to UPMC Health Plan Members covered under these programs.** If services are provided to UPMC Community HealthChoices, UPMC *for Kids,* UPMC *for You* Members or the provider participates with multiple managed care organizations affiliated with those lines of business, the provider is only required to enroll **once per service location.**

If a claim is denied due to the lack of a PROMISe ID, the provider **may NOT balance bill** a UPMC Health Plan Member. If there are any questions or issues with the enrollment process, contact the **Department of Human Services' Provider Enrollment Hotline** at **1-800-537-8862, select option 2, then option 4. Finally, choose option 2** to speak to a representative. Providers may also contact their UPMC Health Plan physician account executive.

PROMISE ID Revalidation
The Department of Human Services (DHS) **must** revalidate the enrollment of all providers **at least every five years.** In order to do this, DHS requires that all providers re-enroll **at least every five years** by submitting a fully completed Pennsylvania PROMISe Provider Enrollment Application for every active and current service location.

The provider may revalidate a PROMISe ID by accessing the following website: **provider.enrollment.dpw.state.pa.us**

Additional information can be found in the **Medical Assistance bulletin #99-16-06** located at **p.widencdn.net/4o81qa/Revalidation-of-MA-Providers.**

A provider **may** obtain their next re-enrollment deadline by logging in to the provider portal for each service location. The revalidation date will be displayed in the masthead of the provider portal for each service location.

Background:

Section 6401(a) of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively known as the Affordable Care Act or ACA) added a requirement that states revalidate the enrollment of providers. The Department of Health and Human Services (HHS) issued implementing regulations, which can be found at **42 CFR 455.414(c).** The ACA and implementing regulations require states to revalidate the enrollment of providers **every five years.**

Procedure:

To revalidate, providers **must** submit a complete Pennsylvania PROMISe™ Provider Enrollment Application to DHS for **every active and current** service location. Providers **may** view enrollment requirements and applications at **dhs.pa.gov/provider/promise/enrollmentinformation.**

Providers can submit their applications in one of the following ways, unless otherwise specified in the application instructions:

- **Online** through the Electronic Provider Enrollment Application available at: **provider.enrollment.dpw.state.pa.us**
- **Email: Ra-ProvApp@pa.gov**
- **Fax: 717-265-8284**
- **Mail: DHS/OMAP/BFFSP**
  Attention: Provider Enrollment
  PO Box 8045
  Harrisburg, PA 17105-8045

Alert— Enrollment Application Changes

Providers **must** inform the Department of Human Services (DHS) of any changes to the information in their enrollment application, including changes in direct or indirect ownership and controlling interest of **5 percent or greater**, contract information changes, address changes (including email addresses), closed or invalid service locations, or any information that would render the information in their enrollment application or provider file inaccurate or incorrect.

➢ **See:** ***Disclosure of Ownership and Control,*** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

Disclosure of Ownership and Control

UPMC Health Plan is required to obtain information from network providers concerning disclosure of ownership, controlling interest, and management information. UPMC Health Plan collects this information for all participating providers ("Disclosing Entity"). The information **must** be submitted **within 30 days** of a request and updated **at minimum every three years** thereafter.

The following information is required:

- The identity of the Disclosing Entity
- The identity of all owners and others with a controlling interest in the Disclosing Entity
- Disclosure of familial relationships between owners and others with a controlling interest in the Disclosing Entity
- Disclosure of ownership or controlling interest in other Disclosing Entities
- The identity of officers, directors, and board members
- The identity of managing employees and agents
- Disclosure of ownership or controlling interest in subcontractors
- Disclosure of familial relationships between owners and others with a controlling interest in the Disclosing Entity and owners and others with a controlling interest in subcontractors
- Identifying information includes, but it is not limited to:
    - Name.
    - Address.
    - Date of birth.
    - Social Security number (SSN).
    - Tax identification number (TIN).

An electronic form and definitions can be found at **upmchp.us/provider-disclosure-form.** Each section of the form **must** be completed unless the disclosing provider has attested that the section is not applicable. If any fields are left blank the form **will not** be processed and it will be returned for corrections and/or additional information.

Completion of the disclosure is a provider contractual obligation and condition of all providers for participation in the UPMC Health Plan network. Failure to submit the requested information may result in denial of network participation or termination of existing Provider Agreements.

After receiving a completed Disclosure of Ownership and Control form, UPMC Health Plan will review the data and run the names of all the entities and individuals disclosed through the Disclosure of Ownership and Control form against the Federal and State Database Check process. This process includes a review and comparison of the disclosed information to the following lists:

- U.S. Department of Health and Human Services Office of Inspector General's (HHS OIG) List of Excluded Individuals/Entitles (LEIE) database
- Medicheck Listing
- Social Security Administration Death Master File (SSADMF)
- System for Award Management (SAM)
- Any other applicable state exclusion list, including other state Medicaid programs

The State also identifies individuals and entities that have been sanctioned, excluded, or terminated from participation in federal health care programs, and providers who have relationships with those individuals or entities. Any adverse information found during the disclosure and Federal and State Database Check process is submitted to the State.

In the event of a positive exclusion list match, UPMC Health Plan will notify the disclosing entity and request a written corrective action plan addressing the actions the disclosing entity has/is taking to address the status of the excluded party.

For additional information or assistance, providers should contact their UPMC Health Plan provider network contact or call **UPMC Provider Services** at **1-866-918-1595,** Monday through Friday, from 8 a.m. to 5 p.m.

Closer Look at Exclusion Status

UPMC Health Plan is required under **42 C.F.R. §455.436** to check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents, and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration's Death Master File (SSADMF), the National Plan and the Provider Enumeration System upon enrollment and re-enrollment; and check the LEIE and SAM **no less frequently than monthly.** UPMC Health Plan is required to check the SSADMF **at the time of initial enrollment and re-enrollment** as well as providers, owners, agents, and managing employees against the LEIE and SAM **on a monthly basis.**

Provider Sanctioning

UPMC Health Plan follows a **three-phase process** for addressing the actions of providers who fail to observe the terms and conditions of the provider agreement or UPMC Health Plan's policies and procedures.

The, QPAC made up of practicing physicians and UPMC Health Plan employees, sets the sanctioning guidelines and oversees any corrective or disciplinary action involving network providers.

Closer Look at the QPAC

The QPAC, represents both academic and community providers, who provide valuable input directly under the auspices of the committees of the Quality Governance Structure ultimately reporting to the Quality Committee of the Board. The QPAC is vital to UPMC Health Plan because it develops and evaluates clinical and operational standards for providers. The Provider Agreement requires providers to comply with UPMC Health Plan's Quality of Care Program. To obtain additional information, providers may go online at **upmchealthplan.com/providers** or call **Provider Services,** Monday through Friday, from 8 a.m. to 5 p.m. at the appropriate number listed below.

UPMC Health Plan Provider Services Contact Information	
UPMC Health Plan Products	**Phone Numbers**
UPMC Community HealthChoices (Medical Assistance)	**1-844-860-9303**
UPMC Behavioral Health Services (BHS)	**1-866-441-4185**
UPMC *for Kids* (CHIP)	**1-866-918-1595**
UPMC *for Life* (Medicare)	**1-866-918-1595**
UPMC *for Life* Complete Care (HMO D-SNP)	**1-866-918-1595**
UPMC *for You* (Medical Assistance)	**1-866-918-1595**
UPMC Health Plan (Commercial including FEHB and PSHB)	**1-866-918-1595**

Actions That Could Lead to Sanctioning

Actions that could lead to sanctioning fall into **three** main categories:

- Administrative noncompliance
- Unacceptable resource utilization
- Quality-of-care concerns

Administrative Noncompliance

Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of UPMC Health Plan. Examples include:

- Conduct that is unprofessional or erodes the confidence of UPMC Health Plan Members
- Direct or balance billing for services
- Failure to coordinate or cooperate with UPMC Health Plan's administrative, quality improvement, and utilization review and reimbursement procedures

Unacceptable Resource Utilization

Unacceptable resource utilization is a utilization pattern that deviates from acceptable medical standards and may adversely affect a Member's quality of care.

Quality of Care

A quality-of-care issue may arise from an episode that adversely affects the functional status of a Member or a pattern of medical practice that deviates from acceptable medical standards. For quality-of-care concerns, a severity scale is utilized. The severity level indicates adverse effects or potential adverse effects on the patient.

The sanctioning process and focused monitoring of the provider remain in effect for **no less than one year** from the date the provider is notified by a UPMC Health Plan medical director. The provider is notified when the process and follow-up activities are satisfied, and the sanctioning is **no longer** in effect. In instances of recurring similar noncompliance activities, UPMC Health Plan reserves the right to expedite the sanctioning process.

Corrective Action Phases

Corrective action is imposed in **three** phases, with providers entering successive phases only if they fail to adhere to the corrective action imposed in the previous phase.

Phase I—Education Phase

The **first** phase involves reviews and interviews between the provider and a UPMC Health Plan medical director. This phase also includes follow-up notices outlining the action expected of the provider.

Phase II—Practice Limitations or Suspension Phase

During the **second** phase, if performance continues to be unacceptable, practice limitations or suspension will be recommended.

Phase III—Recommendation for Termination

In the **third** phase, if the provider has continued to exhibit unacceptable behavior or **has not** performed to acceptable standards, there will be a recommendation for consideration of termination.

> ➢ **Note:** If the UPMC Health Plan Medical Director determines that based on their sole discretion, a Member is in imminent danger because of the actions or inactions of a participating provider/practitioner, the UPMC Health Plan Medical Director **may** impose disciplinary action including:
>
> - Immediate suspension or restriction of the practitioner/provider's network participation status; or
> - Phase III Recommendation for termination from the network.

Phase III recommendation for termination **may be** invoked by the UPMC Health Plan's Medical Director based on the severity level without the provider/practitioner entering Phase I or Phase II of the process.

Provider Termination

The QPAC, as part of the sanctioning process, may recommend the termination of a provider contract. The provider will be notified in writing and offered the opportunity to appear at a hearing, if appropriate.

The termination process involves the following steps:

1. **Medical director notifies provider about termination.**
   The provider will be given notice stating that a professional review action was recommended and the reasons for the proposed action. The provider has the right to request a hearing **within 30 calendar days.**

2. **Provider may request a hearing.**
   If a hearing is requested, the provider will be given notice stating the place, time, and date of the hearing—to occur **no later than 60 calendar days** from the date of the request—and the names of witnesses, if any, expected to testify on behalf of UPMC Health Plan.

3. **The QPAC appoints an Appeals Committee.**
   The Advisory Council will appoint an Appeals Committee on an ad hoc basis. The Advisory Council **will not** select as Members of the Appeals Committee anyone in direct economic competition with the provider who is the subject of the hearing or anyone who has previously voted on the action.

4. **Appeals Committee conducts hearing and makes recommendations.**
   After the QPAC recommends termination of participation status or other sanction, the Appeals Committee will hear the appeal from a provider if the QPAC—in its sole discretion—offered the provider the opportunity to appeal. The Appeals Committee will conduct the hearing and recommend to the QPAC that it accept, reject, or modify its original recommendation. The right to the hearing may be forfeited if the provider fails, without good cause, to appear.

   At the hearing, the provider has the right to:
   - Receive representation by an attorney or another person of the provider's choice.
   - Have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation of the records.
   - Call, examine, and cross-examine witnesses.
   - Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law.
   - Submit a written statement at the close of the hearing.

Upon completion of the hearing, the provider has the right to receive the written recommendation of the Appeals Committee from UPMC Health Plan in an expeditious and appropriate manner, including a written statement giving the basis of the decision.

Integrated Denial Notice

If a UPMC *for Life* (Medicare) and/or UPMC *for Life* Complete Care (HMO D-SNP) provider is considering a procedure that **may not** be covered by UPMC Health Plan, even if prior authorization **is not required,** a prior authorization **must** be requested before performing the procedure. A prior authorization request may be submitted through Provider OnLine at **upmchealthplan.com/providers.** If the request is approved, UPMC Health Plan will consider the procedure for reimbursement.

If the procedure is **not** approved, both the provider and the Member will receive an Integrated Denial Notice (IDN) from UPMC Health Plan explaining the denial. If the Member would like to move forward with the procedure, the provider **must** obtain a signed financial responsibility waiver from the Member and bill the Member directly for the service(s). **Even if the provider receives a signed financial waiver an IDN is still needed to bill the Member.**

It is important to note that all steps in the approval process **must** occur **BEFORE** the procedure takes place. If the provider seeks approval **AFTER** the procedure, UPMC Health Plan can automatically deny the request with no Member liability.

Below are some general guidelines on covered procedures:

- **Excluded services** would include services **not** considered medically necessary, personal items in a hospital or skilled nursing facility, full-time home nursing care, custodial care, homemaker services, reversal of sterilization procedures, nonprescription contraceptive supplies, and naturopath services.
- **Services potentially covered** under specific conditions include experimental/investigative procedures when covered under a Medicare or plan-approved clinical trial; private hospital room if medically necessary; supportive devices for the feet; orthopedic shoes; and cosmetic surgery in cases of accidental injury, breast reconstruction, or other malformed body member.
- **Services not typically covered** but which **may** be based on plan design at UPMC Health Plan include routine/preventive dental care and routine chiropractic, podiatry, hearing, and vision services.

If providers are unsure about any of the guidelines or a specific procedure, it is strongly recommended that they request an authorization to avoid waiving all Member liability for the services. More information about these guidelines or the approval process can be obtained by contacting **Provider Services** at **1-866-918-1595,** Monday through Friday from 8 a.m. to 5 p.m.

Additional information can be found in:

- **Chapter 4, Section 3,** of the Evidence of Coverage (EOC) on Provider OnLine. The EOC can be found on the Eligibility Details page under Schedule of Benefits for the specific Member enrolled in the plan.

- **Chapter 4, Benefits and Beneficiary Protection, Section 160,** of the Medicare Managed Care Manual.

- **Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance** in the Medicare Managed Care Manual; 40.12.1- Part C Notification Requirements.

➢ **See:** ***Covered Benefits and Services for HMO and PPO Members,*** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life*.

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