



Community LIFE

Contracted Provider Manual

February 1, 2011

Our Mission:

Community LIFE is a Program of All-Inclusive Care for the Elderly, committed to enabling frail, older adults to remain at home while preserving their dignity, independence, and quality of life.

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I. Overview of the Community LIFE Program

Welcome to the Community LIFE contracted health provider network. We are a provider and payor of health services to the frail elderly, and this manual will provide you with an understanding of how Community LIFE works, and how to receive authorization and payment for the services you provide.

Community LIFE is a Program of All-Inclusive Care for the Elderly, a comprehensive benefit of health and social services for the frail elderly authorized by the Balanced Budget Act of 1997 (BBA). Known as **LIFE** (Living Independence for Elders) in Pennsylvania, this unique model integrates primary, acute, post-acute, and long-term care services to keep nursing home-eligible persons living in their own home. Medicare and Medicaid make capitated payments to Community LIFE for their enrolled beneficiaries, who are called “**participants**”. Community LIFE manages and pays for all covered services, while providing primary care and home and community-based services to support the individual living at home. The integration of Medicare and Medicaid financing allows the LIFE program to deliver more of the services a person needs to live in his or her setting of choice, without having to navigate two insurance systems and coordinate services among multiple providers.

In accordance with federal regulations and your contracted provider agreement, **Community LIFE coordinates and must authorize all non-emergency services provided to its participants.** Each participant is assigned to an **Interdisciplinary Team** at a local adult/day health (**LIFE**) **Center**. Each participant is issued an identification cards which include the location and telephone number of his/her Community LIFE Center, insurance number, the name of his/her primary care physician, and authorization/billing instructions. Normal business hours are Monday through Friday, 7:30 am – 4 pm; an on call nurse is available 24 hours a day, 7 days a week via a pager by contacting the Center’s main phone number.

The LIFE-Centers provide a single hub for primary care, pharmacy, nursing, restorative therapy, adult day services, care coordination, and social work. Center staff coordinate additional supportive services such as home health care, transportation, home accessibility modifications, and home-delivered meals. Hospital, skilled nursing facility, medical specialty care diagnostics, dialysis, and other services are provided through a network of local contracted health providers . With no annual or lifetime limits, beneficiaries receive all needed care for the duration of their lives, unless they disenroll. There are no deductibles or co-pays, and no premiums for persons eligible for Medical Assistance.

The care of the PACE elder is managed by the **interdisciplinary team, or “IDT”**, which consists of the daily providers of hands on care – Physician, nurse, social worker, dietician, recreation staff, therapists, aides and even drivers - who assess the individual frequently and design an individual care plan. This increases preventive care and the opportunities for patient education, reducing the likelihood of emergency room use, hospitalization, falls, and other negative events.

To be **eligible** to enroll as a Community LIFE participant, an individual must be:

- At least 55 years of age or older.
- Eligible for Medicare and/or Medicaid or have ability to private pay.
- Reside in Community LIFE’s designated service area.

- Be assessed by the authorized state agency as nursing home eligible.
- Be able to live safely at home with the help of Community LIFE.

The key **advantages** of Community LIFE to the frail elder are:

- **Freedom and dignity** of living in the community in the residence of one's choice.
- **Comprehensive and coordinated services** - an Interdisciplinary Team (IDT) manages, approves, and arranges all services from medical appointments to delivery of equipment and supplies. A participant does not have to search and inquire to get his or her needs met or trying to navigate complex systems on their own. The team meets daily to discuss changes in participants' conditions and can adjust care plans and services quickly. Face-to-face contact with a Community LIFE staff member is very frequent, in many cases daily, identifying problems in their early stages.
- **Preventive Care** which reduces risk of emergency room visits and hospitalizations.
- **Adult Day Care**, when necessary, is included in the benefit.
- **No deductibles or co-payments for covered services, including prescription medications.**

II. Authorization of Services

Authorization verification or inquiries about specific services, unless otherwise noted, should be directed to the "Authorization and Precertification" phone number on the participant's Community LIFE ID card. With the exception of emergency care, all services must be authorized in advance by Community LIFE.

Emergency Care: Participants do not need prior authorization for emergency care.

Routine Health Services, Supplies, and Equipment:

- An appointment with a health provider made by Community LIFE on behalf of the participant will be considered authorization for services when the "Consult Summary" form is completed and returned to the participant's Community LIFE Center.
- Appointments scheduled directly by a participant will not be considered authorized for payment.

Inpatient Hospitalization:

- Admissions: Community LIFE participants will be admitted to Geriatric Services or other attending physician, or an appropriate consultant based on the participant's condition. Community LIFE will make every reasonable effort to contact the admitting physician directly to establish and maintain effective communication.
- Network participating hospitals include: Magee-Womens Hospital of UPMC, UPMC McKeesport, UPMC Mercy, UPMC Presbyterian, UPMC Shadyside, and UPMC St. Margaret
- Surgical Consults:

- i. The attending physician will coordinate all preoperative care and evaluation, obtaining any additional consultation required.
 - ii. During surgery and the immediate post-operative period (first 23 hours), the surgeon will be the attending physician with primary responsibility for management of the participant. This period may be lengthened or shortened based on circumstances and/or by mutual consent of the surgeon and the Community LIFE physician.
 - iii. Following the immediate post-operative period, the Community LIFE physician will again assume primary responsibility for patient management with the advice and consultation of the surgeon related to management of the surgical condition. If there is concern that the surgical condition remains unstable, either physician may request additional consultation to clarify the appropriateness of this responsibility transfer.
- d. Medical Consults :
- i. The attending physician and will authorize consults.
 - ii. Consulting Physicians are not authorized to refer to sub-specialists or contract with other physicians on behalf of Community LIFE.
- e. Utilization Management Process and Requirements:
- i. Hospital to provide initial admission notification within 24 hours or next business day via the "Authorization and Precertification" phone number on the participant's Community LIFE ID card.
 - ii. An admission authorization is issued only after an initial clinical update is provided that demonstrates medical necessity.
 - iii. Hospital provides daily clinical updates that include a clinical justification for continued hospital stay and progress toward discharge plan.
 - iv. Discuss any post acute service, supply or DME needs with Community LIFE Social Worker as soon as possible to determine if Community LIFE will provide directly or to obtain the name/phone # of a network provider and to reactivate any established in-home care aide support.
 - v. Fax copy of discharge summary and medication list or current MAR as soon as tentative discharge date is noted to the participant's Community LIFE Center Clinic.
 - vi. Additional clinical justification and treatment goals, approval by the IDT and a unique authorization is required for the following:
 - 1. Transfers to lesser level of care facilities (SNF's, LTAC's and Acute Inpatient Rehab facilities (Community LIFE does not require a 3 day hospitalization prior to admission to a skilled nursing facility.)
 - 2. Any post acute services i.e. home care, OP therapy, DME, transportation.
 - vii. Retrospective authorizations will not be issued.

- f. **Discharge Planning:** With the resources available to Community LIFE for out-of-hospital management, we are generally able to discharge participants with enhanced outpatient support to transitional care earlier than is typical and without compromising their care. We ask our hospital attending physicians to inform participants and their families that they will be working with the Community LIFE physician(s) to determine when discharge is appropriate rather than providing information on typical lengths of stay for the participant's condition or procedure.

Skilled Nursing Facility:

- a. Transfers require review of a clinical justification and treatment goals by the IDT. When approved, a unique authorization is issued. Network participating Skilled Nursing Facilities include: Charles Morris, The Heritage of Shadyside, The Willows, Seneca Place, Riverside Care Center, Kane Regional McKeesport and Kane Regional Glen Hazel
- b. Admission to a Skilled Nursing Facility does not require a 3 day prior hospitalization.
- c. Specialty services require prior authorization, including the following routine care:
 - i. Podiatry – visits every 12 weeks for nail care
 - ii. Audiology - annual screening
 - iii. Optometry - annual eye exam
 - iv. Dental – annual exam and cleaning
- d. All other non-emergency care, procedures, testing, equipment, and supplies not covered in the nursing facility contract per diem must be authorized by the Community LIFE IDT.
- e. Retrospective authorizations will not be issued

III. Covered Services

Covered Services in the United States and U.S. Territories:

- 1. All Medicare-covered items and services; and**
- 2. All Medicaid-covered services, as specified in the State's approved Medicaid Plan; and**
- 3. Other services determined necessary by the Community LIFE Interdisciplinary Team to improve and maintain the participant's overall health status.**

All non-emergency services require prior authorization.

In order for services to be covered, Participants may not leave Community LIFE's designated service area (even when traveling within the United States) for more than 30 days without authorization and specific care arrangements by the Interdisciplinary Team.

Emergency Care

1. Participants do not need prior authorization for emergency care.
2. An **emergency medical condition** means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to one's health, serious impairment do bodily functions, or serious dysfunction of any bodily organ or part.
3. Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach a Community LIFE staff member, physician, or contract provider would risk permanent damage to the participant's health.
4. Emergency care may be furnished by any qualified emergency services provider either in or out of the Community LIFE service area.
5. Emergency care includes services needed to evaluate or stabilize an emergency medical condition.

Excluded Services:

2. Any service not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.
3. Private room or private duty service in an inpatient facility unless medically necessary.
4. Non-medical items for personal convenience in an inpatient facility unless specifically authorized by the Interdisciplinary Team .
5. Cosmetic surgery unless it is required for improved functioning of a malformed part of the body resulting from accidental injury or for reconstruction following mastectomy.
6. Experimental medical, surgical, or other health procedures.

Outside the U.S.

Community LIFE will cover the following services in Canada or Mexico **if** (a) the participant has a medical emergency while **in** the U.S. and a Canadian or Mexican hospital that can treat the emergency is closest, or (b) if the participant is crossing through Canada without delay on the most direct route between Alaska and another state:

1. Inpatient hospital care
2. Doctor's services in the hospital only
3. Ambulance service to the hospital only

IV. Billing Procedures

Claims for services should be submitted on standard CMS 1500 or UB04 forms with appropriate ICD-9 and CPT codes within 180 days for Hospitals and Nursing Facilities and within 90 days for all other providers to receive payment. To ensure timely payment, providers should inform their billing departments that in order to receive payment, they must bill Community LIFE directly and **NOT** Medicare or Medicaid. ***Contracted providers may not balance-bill a Community LIFE participant (enrolled plan member).***

Mail Claims to:

Community LIFE Provider Claims
P.O. Box 2979
Pittsburgh, PA 15230

Phone: 1-888-674-8762

Pharmacy Claims are submitted electronically as follows:

Express Scripts, Inc.
Rx BIN: 003858
Rx PCN: A4
Rx GRP: PM4A
Issuer: (80840)

A claim will be reviewed for the following **criteria for adjudication**:

- Member eligibility on date of service
- Referral and/or authorization by Community LIFE
- Covered benefit
- Timely claims submission

A claim is considered appropriate for **denial** if:

- The participant was not eligible at time of service
- Service is not covered under the plan
- Claim was not submitted with time frame defined for timely filing
- Claim does not contain sufficient information for processing
- The service is determined to be non-emergent/non-urgent and not authorized
- Code Review determines that the procedure billed is not appropriate based on AMA standards.

Re-consideration (appeal of a denied claim)

A re-consideration is a written request by a service provider for payment of a claim that was previously denied.

Third Party Claims Administrator (TPA) will forward all documentation it receives regarding a re-consideration to Community LIFE for review.

- If the claim denial is upheld, Community LIFE will send a letter to the provider communicating their decision to uphold the denial. Community LIFE will send a copy of the letter to TPA.
- If claim payment is approved, Community LIFE will communicate to TPA in writing that payment is approved. TPA will reinstate the claim for payment on the next scheduled pay run.

Administrative Denial – issued when Facility fails to provide timely notification of hospital admission or appropriate initial/subsequent clinical justification

Request for reconsideration of payment may be submitted to **Appeals, Community LIFE, 2400 Ardmore Blvd, Suite 700, Pittsburgh, PA 15221**, with the following information: letter of explanation, dates of service, EOP, H&P, physician progress notes, consults, significant diagnostic results and discharge summary.

- If the administrative denial is upheld, Community LIFE will send a letter to the provider communicating the decision to uphold the denial and forwards a copy of the letter to the TPA.
- If the administrative denial is approved, Community LIFE will communicate to TPA in writing that payment is approved. TPA will reinstate the claim for payment on the next scheduled pay run.

V. **Quality Oversight and Care Coordination**

Community LIFE has a Quality Assurance Performance Improvement Plan (QAPI) that includes both internal and external review processes. This program monitors quality through utilization review, outcomes of care, chart audits, customer complaints and satisfaction surveys, and other tools to enhance program quality and effectiveness. A willingness to cooperate with and participate in this review process is expected of all providers.

Community LIFE has a Plan Advisory Committee composed of plan participants (consumers), and members of the community with experience related to the provision of services for and advocacy of the elderly, including a representative from the Area Agency on Aging. The Plan Advisory Committee functions as the Quality Committee of the Board of Directors, and reviews service denials, enrollment denials, and grievances not resolved by Community LIFE staff.

Credentialing:

Contracted Providers who provide services and care to our participants are required to provide the following information initially and updated as needed:

- Medicare/Medicaid Provider and National Provider Identification (NPI) Numbers

- Current Valid Professional License or Facility License as applicable
- Liability Coverage Face Sheets for general and professional insurance coverage
- Certificate of Accreditation (if applicable)
- W-9 IRS Form
- Proof of Worker's compensation insurance – including the Coverage Face Sheet

Community LIFE verifies and or requires that providers:

- Have required license or certification to perform their duties;
- Have not been excluded from participation in Medicare or Medicaid Programs;
- Have not been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other federal health care programs;
- Have proof of the following for staff that have direct contact with participants and work on Community LIFE property or in participants' homes:
 - a. Criminal clearances showing the person has not been convicted of any criminal offense which could jeopardize the health, safety, or well-being of any participant including but not limited to physical, sexual, drug or alcohol abuse, or any prohibited offense under the Pennsylvania Older Adults Protective Services Act;
 - b. Are medically cleared for communicable diseases and have up-to date immunizations required for their jobs;
 - c. Have one year of experience with a frail or elderly population;
 - d. Are oriented to Community LIFE program benefits and applicable procedures;
 - e. Meet competency requirements where required for their duties.

Monitoring:

Regular monitoring and auditing may include utilization data, outcomes of care, satisfaction, and record audits, depending on the provider type.

Community LIFE may conduct on-site episodic inspections or remote investigation of any contract provider who the Plan identifies as having problems based on the following indicators:

- Complaints from participant, family member or staff regarding the quality of care, or allegations of abuse;
- Patterns of complaints or poor outcomes;
- Serious adverse events resulting in the need for hospitalization, permanent loss of function, or death.

Care Coordination:

Nursing Facility Providers are expected to cooperate with C-LIFE care coordination and quality oversight activities including:

- Providing C-LIFE current orders and plan of care of the Contractor, which C-LIFE is required to keep in its own participant health record; and
- Simultaneously notifying participant and C-LIFE of care plan meetings and allowing a C-LIFE Interdisciplinary Team member to participate in the Contractor's care plan meetings; and
- Designating a key staff to participate, with reasonable notice, in the C-LIFE care plan meeting upon request; and
- Allowing C-LIFE Interdisciplinary Team members to conduct in-person assessments and routine visits with participants residing in the Contractor's facility; and
- Notifying C-LIFE of participant incidents, and significant changes of health status within 24 hours; and
- Notifying C-LIFE immediately of any emergency hospitalization; and
- Cooperating with C-LIFE management in the resolution of complaints by the participant or his/her family/legal representative about the quality of care delivered by C-LIFE or the Contractor; and
- Responding to C-LIFE requests to address serious adverse outcomes or patterns of complaints or sub-standard care; and
- Seeking prior authorization from C-LIFE for all non-emergency medical care not included in the Contractor daily per diem, changes in skill level or adding a skilled service to a participant care plan. C-LIFE may routinely pre-authorize certain specialty services as outlined in the Community LIFE Contracted Provider Manual.

Hospital Providers

In addition to the Utilization Management processes in Section II, Hospital Providers and their staff are expected to

- Allow Community LIFE staff to visit participants in the hospital and review the medical record to assist in the coordination of care;
- Provide copies of pertinent medical record items within 30 days;
- Cooperate and communicate with Community LIFE staff to coordinate participant care. This includes hospital physicians responding to inquiries of the CLIFE primary care physician.

VI. PACE Participant Bill of Rights

Federal PACE Regulations require that all contractors be aware of Participant Rights.

All PACE participants in Community LIFE have the right:

Right #1: Respect and Nondiscrimination

1. To receive comprehensive health care to promote the enrollee's functional ability to the optimal level and to encourage independence in a safe and clean environment.
2. To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care, and be provided humane care.
3. Not to be required to perform services for the PACE organization.
4. To have reasonable access to a telephone.
5. To be free from harm, including physical or mental abuse, neglect, corporeal punishment, involuntary seclusion, excessive medication, and imposed for purposes of discipline or convenience and not required to treat the participant's medical symptoms.
6. To be encouraged and assisted to exercise rights as a participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights.
7. To be encouraged and assisted to recommend changes in policies and services to PACE staff.

Right #2: Information Disclosure

1. To be fully informed in writing of the services available from the PACE organization, including identification of all services that are delivered through contracts, rather than furnished directly by the PACE organization before enrollment, at enrollment and when there is a change in services.
2. To have the enrollment agreement fully explained in a manner understood by the participant and responsible party (family) and/or caregiver.
3. To examine or upon reasonable request, to be assisted to examine the results of the most recent review of the PACE organization conducted by HCFA or the State administering agency and any plan of correction in effect.

Right #3: Choice of Providers

1. To choose his or her primary care physician and specialists from within the PACE network
2. To request that a qualified specialist for women's health services provide routine or preventive women's health services.
3. To disenroll from the program at any time.

Right #4: Access to Emergency Care

1. To access emergency health care services when and where the need arises without prior authorization by the PACE multidisciplinary team.

Right #5: Participation in Treatment Decisions

1. To have all treatment options explained in a culturally competent manner, and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.
2. To have the PACE organization explain advance directives and to establish them, if the participant so desires.
3. To be fully informed of his or her health and functional status by the multidisciplinary team.
4. To participate in the development and implementation of the plan of care.
5. To request a reassessment by the multidisciplinary team.
6. To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
7. To attend or to refrain from attendance and participation in religious activities, if offered.

Right #6: Confidentiality of Health Information

1. To communicate with health care providers in confidence and to have the confidentiality of his or her individually identifiable health care and other information protected, including information contained in an automated data bank. Each participant also had the right to review and copy his or her own medical records and request amendments to those records.
2. To be free to contact and meet privately with representative of the Long-Term Care Ombudsman Program.
3. To have his or her written consent to be obtained for the release of information to persons not otherwise authorized to receive it.
4. To provide written consent that limits the degree of information that the persons to whom information may be given

Right #7: Complaints and Appeals

1. To be encouraged and assisted to voice complaints to PACE staff and outside representatives of his or her choice, free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff.
2. To appeal any treatment decision of the PACE organization, its employees or contractors through the appeals process.

VII. Grievance and Appeal Process

Federal PACE Regulations require that all Contractors be aware of Community LIFE's Grievance and Appeal Process.

It is the policy of Community LIFE to assure that all participants enrolled, understand and have access to the established Grievance and Appeals Process.

A **grievance** is a complaint, either oral or written, formal or informal, expressing dissatisfaction with service delivery or the quality of care furnished. Examples: Participant tells staff member a network physician was rude or the van was later than the scheduled time for pick-up.

An **appeal** is a Participant's action taken with respect to the Community LIFE's non-coverage of or non-payment for a service, denial of enrollment, or involuntary disenrollment from the program. Examples: Participant requests motorized wheelchair and Community LIFE denies because the person is deemed unable to operate it safely; Participant protests Community LIFE's plan to reduce home care services because participant has recovered from illness/injury.

Summary of Grievance Procedure:

1. If our participant or their family caregiver or designated representative complains to you, please report the complaint to the Center Administrator at the individual's Community LIFE Center (listed in Section IX – Contact Information), or the Compliance Officer at 412-436-1344.
2. If we receive a complaint about a contractor, we expect the contractor to cooperate with Community LIFE in investigating and resolving the grievance.
3. The Center Administrator will report the grievance at the next Interdisciplinary Team meeting or within a period of five working days.
4. If a solution is found by the team and agreed to by the complainant within five working days of the team meeting, the complaint is resolved.
5. If a solution is not found by the team or agreed to by the complainant within five working days, the staff shall forward a written report to Community LIFE's Executive Director, or if the grievance involves medical care, to the program's Medical Director for final action.
6. The Executive Director or Medical Director will investigate and respond to the grievance within five working days accompanied by a notice that if the participant is not satisfied with the outcome, he/she has 30 days to request a review by the Plan Advisory Committee.
7. The Plan Advisory Committee has a 30 day time frame to investigate and answer the complaint.
8. If the decision is wholly or partially adverse to the participant, a copy of the report shall be forwarded immediately to the Department and the local AAA office.

Summary of Appeals Procedure:

1. Participants and their designated representatives or surrogate decision makers may appeal Community LIFE's decision to deny enrollment to the program, deny initiation of a service, or reduce or terminate a service.
2. If the participant is requesting new or increased services, the Community LIFE Interdisciplinary Team has 72 hours to assess the individual and render a decision. The Community LIFE Center Manager will send the participant a written denial with specific reasons for denial or non-payment, and appeal instructions including their right to request an expedited appeals process if they believe their life, health or ability to regain maximum function would be seriously jeopardized absent provision of the service in dispute.
3. The Plan Advisory Committee will review the appeal within 30 days of receipt of the request, or within 72 hours if the expedited process applies.
4. If determination is made in favor of the participant, Community LIFE will continue to provide, or begin to provide services as expeditiously as possible.
5. If the Plan Advisory Committee decision is wholly or partially adverse to the participant, he or she is notified of his/her additional appeal rights through Medicare and Medicaid.
6. Community LIFE will continue to deliver disputed services until a final determination is made, if the appeal is related to termination or reduction of currently furnished services and the participant understands they may be liable for the costs if the determination is not made in their favor.

VIII. Ethics

1. Community LIFE is committed to lawful and ethical behavior including compliance with all applicable federal and state laws and regulations. To achieve that end we have developed a detailed **Compliance and Fraud, Waste, and Abuse (FWA) Program**. Community LIFE became a Part D Prescription Drug Plan Sponsor in 2006 and this area of potential fraud, waste, and abuse is under close scrutiny by the Center for Medicare and Medicaid Services. However, FWA of any type is addressed in the plan. Contractors should be most concerned about accuracy and validity of billing information and the provision of services which are necessary and appropriate.
2. All Directors, Employees, Volunteers, Contractors, and Agents of Community LIFE are expected to comply with the requirements of the Compliance Plan and Code of Ethics. Our Code of Ethics appears below. A summary of our compliance program and a training for employees and contractors can be accessed at the following links:

<http://www.commlife.org/docs/1004-False-Claims-Act.pdf>

<http://www.commlife.org/docs/1005-Reporting-and-Non-Retaliation.pdf>

<http://www.commlife.org/docs/Compliance-Training-General-Staff.pdf>

Community LIFE will discuss specific FWA Auditing requirements with the appropriate contractors, and contractors are required to cooperate with applicable regulations regarding submitting reports to Community LIFE.

3. Contractors should report any suspected violations to Community LIFE's Corporate Compliance Officer (**412-436-1344**) or to the Compliance Hotline (**1-877-785-0006**), or appropriate government agency or law enforcement.
4. Suspected violations of compliance policies and procedures and ethical conduct are subject to disciplinary up to and including suspension of contracts or termination of employment.

COMMUNITY LIFE CODE OF ETHICS:

Community LIFE Directors, Employees, Volunteers, Contractors, and Agents are expected to act in a manner consistent with the following standards:

1. The provision of quality services in a caring, respectful manner. Quality is defined by meeting the needs of the individuals served and standards established for the service.
2. Compliance with applicable laws and regulations.
3. Honest, respectful, and fair interactions with others.
4. Truthfulness in communication and reporting, and diligence in verifying facts and data.
5. Avoidance of conflicts of interest which could impact the decision-making of officers, directors and managers.
6. Avoidance of conduct which causes unwarranted loss of credibility to Community LIFE.
7. Utilizing Community LIFE resources – people, equipment, supplies, funds, information, and intellectual property - in an economical manner while protecting against loss, theft, misuse, or damage.

IX. Emergency Plans and Contact

1. Participants, family members, employees, and contract staff can reach a Community LIFE RN on call twenty-four hours a day, seven days per week who can assist with medical emergencies or connect with administrator on call for other emergencies at the **Main Center phone numbers** listed below.
2. Community LIFE has emergency plans to provide care to participants during bad weather and other potential disasters. Contract staff who would be involved are given specific training at the Community LIFE Center.

X. Community LIFE Contact Information

<u>Title</u>	<u>Phone Number</u>
Contracts and Credentialing	412-436-1335
Medical Director	412-436-3424
Compliance Officer	412-436-1344
Finance Director	412-436-1333
Claims / Authorization Specialist & Coverage Verification	412-436-1331
Utilization Review Manager	412-436-1348
Center Administrator Homestead LIFE Center	412-464-2101
Health Services Coordinator East Liberty LIFE Center	412-362-0805
Center Administrator McKeesport LIFE Center	412-664-1448
Center Administrator Tarentum LIFE Center	724-230-3240

Community LIFE Toll Free Number 866-419-1693