UPMC *for Kids*

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At a Glance

UPMC *for Kids* is available through a contract with the Children's Health Insurance Program (CHIP) of Pennsylvania. CHIP is a state and federally funded program that provides health insurance for uninsured children from birth until they reach the **age of 19**. In 2007, Pennsylvania CHIP was expanded to offer health insurance to children and teens who are not eligible for Medical Assistance, regardless of family income. Enrollment eligibility is evaluated every **12 months**.

The CHIP program offers a wide range of benefits. These include inpatient care, emergency room visits, office visits, preventive care, mental health and substance abuse services, diagnostic services, therapies, home health visits, durable medical equipment, pharmacy, dental (including orthodontia, when medically necessary), and vision services. In addition to these benefits, UPMC *for Kids* offers enhanced services and care options that are not standard CHIP benefits. These enhanced benefits include the UPMC *My*Health 24/7 Nurse Line, *My*Health OnLine, and health promotion programs.

UPMC *for Kids* members must select a primary care provider (or PCP), and they must use providers, services, and facilities within the UPMC *for Kids* network. Members are able to self-direct care to network specialists. PCPs are expected to coordinate care and assist members in finding other services outside of the PCP's specialty. Network providers must obtain the appropriate releases necessary to share clinical information and health records as requested by the member, consistent with applicable state and federal law. Although a referral is not required, network providers will accept referrals from non-network Indian Health Care Providers to refer an Indian enrollee who is a CHIP member, as mandated by 42 C.F.R. § 438.14(b)(5-6).

Based on a family's income, children can be enrolled in ***free* CHIP**, ***low-cost* CHIP**, or ***full-cost* CHIP**. Many families do not have to pay for CHIP. Families with higher incomes have low monthly premiums and copayments for some services. The type of CHIP coverage a family is offered may change as the family's income changes, which may impact copayments. The member's identification card includes information on copayments for PCP visits, specialist visits, emergency room visits, and pharmacy services. Some services have benefit maximums that are based on the UPMC *for Kids* benefit year, which runs from **August 1 to July 31**.

This chapter contains information providers need to know to deliver care to members enrolled in UPMC *for Kids*. Providers should visit **www.upmchealthplan.com** to get the most current information regarding CHIP coverage or to address other issues not covered in this manual. Additionally, providers may call **UPMC *for Kids* Provider Services** at **1-800-650-8762,** from 8 a.m. to 5 p.m., Monday through Friday.

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Alert – Provider Enrollment

All providers who render, order, refer or prescribe items or services to Pennsylvania CHIP members are required to have a valid PROMISe ID (also known as MMIS Provider ID) with the state of Pennsylvania. PROMISe IDs correspond to both the provider and location. Thus, the provider must register an ID for each location at which he or she provides services to CHIP members. If services are provided to both Medicaid and CHIP members or the provider participates with multiple MA and CHIP managed care organizations, 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 CHIP 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. You may also contact your UPMC Health Plan Physician Account Executive.

Key Points

- Having a PCP is mandatory.
- Network providers and facilities must be used.
- Preventive care is covered only if provided by PCPs (or specialists who are credentialed as PCPs).
- Routine physical exams and immunizations for both children and teens (**from birth to age 19**) are covered.
- Most preventive services are fully covered.
- Obstetrician-gynecologists are credentialed for routine gynecological visits and mammogram screenings, even when not credentialed as PCPs.
- Emergency or urgent care by any provider is covered if the member believes he or she is in a life-threatening situation.
- Some services require prior authorization.
- Benefit limitations apply for the following outpatient services:
  - Chiropractic care
  - Habilitative therapy
    - ➢ *See Habilitation Services*, Glossary and Abbreviations, Chapter K
  - Hearing exams and aids
  - Home health
  - Outpatient occupational, physical, and speech therapy
  - Tobacco cessation counseling
  - Vision care

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Covered Benefits

At a Glance

UPMC *for Kids* network PCPs, specialists, therapists, hospitals, skilled nursing facilities, and rehabilitation centers provide a variety of medical benefits, some of which are itemized in the following section.

For information not covered in this manual, contact **Provider Services** at **1-800-650-8762** from 8 a.m. to 5 p.m., Monday through Friday, or go to **www.upmchealthplan.com.**

Ambulance

Ambulance service is covered when using a specially equipped vehicle, which is used only for transporting the sick and injured. Ambulance services are covered when provided to transport a member to the nearest hospital able to treat the condition, between hospitals, and between hospitals and skilled nursing facilities. Services provided to treat a member by on-site ambulance services, without transport, are considered medically necessary. Therefore, are covered when all of the indicators are met.

Nonemergency medical transportation is not covered. In the case of a life-threatening emergency, members should dial **911** or their **local emergency service**.

Ancillary Services

Ancillary services include a wide range of outpatient support services that may be available at a provider's office, a hospital outpatient department, or a member's home.
Ancillary service benefits include, but are not limited to:

- Ambulance services (as listed above)
- Chiropractic services
- Diabetic supplies (including glucometers, test strips, lancets, insulin, and syringes)
    - **NOTE**: Copayments apply for some members under the pharmacy benefit
- Diagnostic services (e.g., ECG, EEG)
- Durable medical equipment (DME)
- Home health care (see In-home Services below)
- Hospice care
- Laboratory services
- Orthotics and prosthetics

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Ancillary services are covered when care is performed by network providers and coordinated by a member's PCP (when applicable), ob-gyn, or network specialist. To find a network provider for a particular service or location, go to **www.upmchealthplan.com.**

- **NOTE**: Ancillary services or equipment may be subject to benefit limitations or require prior authorization.

In-home Services

- Habilitative therapy
  - **NOTE:** Benefit limits are combined with limits for regular physical, speech, and occupational therapy visits.
- Home infusion therapy
- Hospice care
- Physical, speech, and occupational therapy
  - **NOTE:** Limited to **60 visits** per therapy type **per plan year**
- Private duty nursing
  - **NOTE**: Limited to a maximum of **16 hours per day**
- Skilled/intermittent nursing

Closer Look at Specialized Equipment

If a member requires specialized equipment or modifications, the ancillary provider should contact **Utilization Management** by accessing **Provider OnLine** at **www.upmchealthplan.com/providers**.

Utilization Management will be able to verify the amount of the DME benefit used to determine if the equipment is covered, and if prior authorization is required.

Admissions

Admissions to network hospitals must be approved by UPMC *for Kids* prior to a member's admission. Emergency admission, inpatient behavioral health, and substance abuse services are exceptions as they do not require prior authorization by UPMC *for Kids*.

Admissions to a non-participating hospital must be approved prior to admission—with the exception of an emergency admission—and will only be considered if the service cannot be performed at a participating hospital.

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Hospitals are required to notify **Utilization Management** of an inpatient admissions, by the **next business day,** by accessing **Provider OnLine** at **www.upmchealthplan.com/providers**. Emergency hospital admissions do not need prior approval regardless of hospital participation.

The inpatient benefits are described below.

Medical, surgical, mental health, skilled nursing, and rehabilitation hospital admissions:

- Includes pre-admission testing, semi-private room and board accommodations; private accommodations when medically necessary; general nursing care; use of intensive or special care facilities when medically necessary; diagnostic and therapeutic radiological procedures; use of operating room and related facilities; drugs, medications, and biologicals; laboratory testing and services; blood bank services; pre-operative and post-operative care; special tests when medically necessary; therapy services, oxygen, anesthesia, and anesthesia services; and any other services normally provided relating to inpatient hospitalization and skilled nursing inpatient care.
    - **NOTE**: Preauthorization may be required for nonemergency services. There are no visit limits on inpatient hospital services.

Inpatient Mental Health Services:

- Includes services furnished in a state-operated mental hospital, residential facility, or other **24-hour** therapeutically structured services. Covers medical care including psychiatric visits and consultations, nursing care, group and individual counseling, therapeutic services, concurrent care, and services normally provided relating to inpatient hospitalization.
    - **NOTE**: Members may self-refer. There are no day limits. No copays apply.

Inpatient Substance Use Disorder Services:

- Services provided in a hospital of an inpatient nonhospital facility that meets the requirements established by the Department of Health and is licensed as an alcohol/drug addiction treatment program.

- In addition to the hospital admission benefits described above, the member has inpatient substance use benefits. These include:
    - Individual and family therapy interventions.
    - Inpatient detoxification stays.
    - Laboratory and psychological/psychiatric testing.
    - Medication management.
    - Services of physicians, psychologists, psychiatrists, counselors, and trained staff.
    - Substance abuse inpatient rehabilitation and nonhospital residential services.

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Mental health and substance use disorder benefits are managed through UPMC Behavioral Health Services. Providers can access **UPMC Behavioral Health Services** by calling **1-866-441-4185**. Members can call **1-800-650-8762 (TTY 711)** for information about participating mental health and substance use providers and benefits. Representatives are available **24 hours a day, 7 days a week**.

➢ **NOTE**: There are no day limits, and no copays apply.

For information regarding specific member benefits, providers should go to **www.upmchealthplan.com**, or contact **Provider Services** at **1-800-650-8762,** Monday through Friday from 8 a.m. to 5 p.m.

Autism Spectrum Disorders

UPMC *for Kids* covers all eligible members for the diagnostic assessment and treatment of autism spectrum disorders. The following services, when medically necessary, for the assessment/treatment of autism spectrum disorders, are covered:

- Evaluations and tests performed to diagnose autism disorder
- Prescription drug coverage
- Services of a psychiatrist and/or psychologist
- Rehabilitative care including applied behavioral analysis and therapeutic care

Members are eligible to use the expedited appeals process defined in Act 62 for autism related Complaints and Grievances.

➢ **NOTE:** Coverage under this section shall be subject to copayment and any other general exclusions or limitations.

Treatment of autism spectrum disorders must be:

- Identified in a treatment plan.
- Prescribed, ordered, or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, or certified registered nurse practitioner.
- Provided by an autism service provider or a person, entity, or group that works under the direction of an autism service provider.

The following definitions apply to this benefit:

- **Autism Service Provider** means any of the following:
  - A person, entity, or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in the Commonwealth of Pennsylvania; and

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- Any person, entity, or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth of Pennsylvania's Medical Assistance program on or before July 1, 2009.

- **Autism Spectrum Disorders**:
  - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

- **Treatment Plan**:
  - A plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

Dental Benefits

Avesis Third Party Administrators, Inc. administers dental benefits for UPMC *for Kids* members. Routine and restorative dental care is a covered benefit when performed by an Avesis participating dentist. Diagnostic and preventive services such as oral exams, cleanings, and x-rays are covered benefits and do not require prior authorization. Other services may require prior authorization.

Providers may call **Avesis provider services** directly at **1-888-209-1243**. Members may call **Avesis Member Services** directly at **1-888-257-0350 (TTY 711)** from 7 a.m. to 8 p.m., Monday through Friday.

Orthodontia

Orthodontia, is covered when medically necessary but requires a prior authorization by Avesis. Benefits include evaluations, placement, adjustments, retainers, and removal of braces.

Oral Surgery

Oral surgery—consisting of removal of impacted teeth that are soft tissue partially or totally covered by bone, as well as the related anesthesia—is covered as a medical benefit when rendered by a participating provider, if applicable, or by a participating Avesis dental provider. It may be performed at an inpatient or outpatient facility depending on the nature of the surgery and medical necessity. If oral surgery is performed under the medical benefit, some members may have copayments.

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Examples of covered services include:

- Baby bottle syndrome
- Non-dental treatments of the mouth relating to medically diagnosed congenital defects or birth abnormalities
- Removal of partially or fully impacted third molars (wisdom teeth)
- Surgical correction of dislocated or completely degenerated temporomandibular joints
- Surgical removal of tumors, cysts, and infections

Diagnostic Services

Diagnostic services include radiology procedures, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine; pathology testing consisting of laboratory and pathology tests; medical procedures consisting of ECG, EEG, and other electronic diagnostic medical procedures; and physiological medical testing. Some radiology procedures require prior authorization.

➢ See specific benefit designs at **www.upmchealthplan.com.**

Doctor Visits

Based on the specific CHIP program in which the member is enrolled, some members may have copayments for outpatient physician visits. The services listed below are covered.

Allergy services, including:

- Allergy injections
- Allergy serum
- Diagnostic testing

Hearing care services:

- Examinations are limited to **one** routine hearing examination and **one** audiometric examination **per year**
- Hearing aids and fittings are limited to **one per ear, every two years**

Obstetrician-gynecologist services, including:

- Covered diagnostic tests performed in the office
- Maternity care
- Office visits
- Routine gynecological exam and Pap smear
- Surgery and hospital care

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Primary care provider visits, including:

- Covered diagnostic tests performed in the office
- Hospital visits
- Immunizations
- Routine physical exams and well-childcare
- Sick visits

Specialist visits, including:

- Office visits
- Covered diagnostic tests performed in the office
- Surgery and hospital care
- Surgery in the office

Closer Look at Preventive Screenings

UPMC *for Kids* covers preventive screening services included in the periodicity schedule based on the Academy of Pediatrics Bright Futures recommendations. Providers should be sure to use the appropriate code for preventive screenings when administering them at both well-child and sick visits.

Examples of recommended covered screenings include, but are not limited to:

- **Developmental screenings using a validated screening tool.**
  Developmental screenings should be completed at **nine months, 18 months**, and **30 months of age**, using CPT code 96110. Providers should also conduct a structured screening outside of the recommended screening periodicities if medically necessary. A copy of the completed, validated developmental or autism screening tool, that was used to conduct the screening must be retained in the medical record. In addition to the form(s), the medical records should contain documentation of all surveillance, screening, and referral activities.

- **Lead screenings.**
  Blood lead levels testing of all children at **ages one and two years old** and for all children aged **three through six** without a prior confirmed lead blood test. CPT code for lead screening is 83655 (used for both capillary and venous blood draws).

- **Maternal postpartum depression screen.**
  Screening may be done in the PCP or pediatrician's office as part of the well-child visit and covered under the child's benefit when screening is for the direct benefit of the child. CPT 96161 is to be used when coding for maternal depression screening under the child's CHIP benefit. Maternal postpartum depression screening should can be done using a validated tool and completed by the baby's **one-month** visit, and then again at the baby's **two-month, four-months** and **six-months** visits.

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- **NOTE:** Coding for maternal depression screening performed as a preventative service as part of the well child visit incurs no copay or cost to the member.

If an issue is identified, the Early Intervention Program is available for children from **birth to age five** who meet high-risk criteria, who are referred following a developmental screening, or when a parent expresses concerns about the child. The Early Intervention Program helps children to grow and develop. A PCP or other provider can refer a child to the Pennsylvania Early Intervention Program through an agency called **CONNECT** by dialing their Helpline at **1-800-692-7288,** 7:30 a.m. to 3:30 p.m. Monday through Friday**.** Parents may also call the CONNECT Helpline directly if they are interested in Early Intervention services for their children.

- To view the Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule, visit the *Clinical Practice Guidelines* page on **www.upmchealthplan.com/providers.**

Emergency Services

Coverage for emergency room visits is provided for the sudden onset of a medical condition(s) with symptoms that are of such severity or pain that someone with an average knowledge of health and medicine could reasonably expect that not receiving immediate medical attention could result in one of the following:

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

Some members have a copayment for emergency room visits. This is identified on their member ID card. The copayment is waived if a member is admitted to the hospital. If the member is admitted, the admitting physician or facility should notify the member's PCP within **24 hours** or as soon as reasonably possible.

Closer Look at Emergency Admissions

Emergency admissions, do not need prior approval regardless of the hospital's participation in the network. The hospital or facility must notify **Utilization Management,** by accessing **Provider OnLine** at **www.upmchealthplan.com/providers**, within **24 hours** or on the **next business day** following the emergency admission.

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Outpatient Mental Health and Substance Use Disorder Services

Outpatient Mental health visits include:

- Individual, group and family therapy
- Intensive outpatient (IOP) sessions
- Medication checks
- Neuropsychological and psychological testing
- Outpatient mental health sessions
- Partial hospitalization sessions
- Targeted mental health case management

Outpatient substance use disorder services are provided in a facility licensed by the Department of Health as an alcohol/drug treatment program. Coverage includes:

- Individual and family therapy
- Intensive outpatient therapy
- Laboratory and psychological/psychiatric testing
- Medication management
- Partial hospitalization sessions
- Services of physicians, psychologists, psychiatrists, counselors, and trained staff

Mental health and substance use disorders benefits are managed through UPMC Behavioral Health Services. Providers can access **UPMC Behavioral Health Services** by calling **1-866-441-4185**. Members may call **1-800-650-8762** for information regarding participating mental health and substance use providers and benefits.

- **NOTE:** There are **no limits** for mental health outpatient visits or substance use services visits **per benefit year**, and no copays apply.

Outpatient behavioral health and substance use disorder services do not require a prior authorization by UPMC *for Kids*.

Alert – Care Coordination

Members may self-direct care to a behavioral health provider. Network providers should coordinate care and services with a member's behavioral health provider as applicable, such as providing consultations and sharing medical and prescription information with the member's consent. Members do not have to obtain a referral from their PCP. Providers should assist members in finding social support services if a need is identified through assessment.

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Pediatric Case Management

The following case management programs are available at no cost to the member. Members or their parents can call **1-866-778-6073 (TTY 711)** and ask to speak with a pediatric case manager. Provider offices can make a referral for pediatric case management for a member by calling **Provider Services** at **1-855-772-8762,** or sending an email to **healthplansparef@upmc.edu.**

- **Pediatric Physical Health**
  - Elevated Lead program
  - General Pediatric Case Management
  - General Pediatric Post Discharge follow-up
  - Healthy Families Program (focusing on healthy habits for **six to 12 year olds**)
  - NICU Post-Discharge Case Management program
  - Pediatric Asthma Case Management
  - Pediatric Diabetes Case Management
  - Pediatric Epilepsy (Start SMART program)
  - Pediatric First Steps Program (focusing on **newborns to three year olds**)

- **Pediatric Behavioral Health**
  - Coordination of care with Children, Youth, and Families (CYF) Services or Juvenile Probation Offices (JPO) for members in Substitute Care
  - Follow-up after pediatric Behavioral Health inpatient stay
  - General Behavioral Health assistance
  - Pediatric ADHD case management program
  - Pediatric Antipsychotic medication follow-up

Outpatient Surgery

Medically necessary outpatient surgery is covered when provided at a participating UPMC *for Kids* facility and when coordinated by the member's PCP (when applicable), ob-gyn, or network specialist. Some procedures may require prior authorization.

Outpatient Services

Services must be provided at a participating UPMC *for Kids* provider or facility. Benefit limitations may apply. Covered services are listed below.

- Chiropractic services:
  - Up to **20** therapeutic manipulation visits **per benefit year**, including consultation, x-rays, and other tests necessary in the treatment plan.
    - **NOTE:** Prior authorization must be obtained for children **13 years of age or younger**.

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- Clinical trials and research studies:
  - Routine clinical services available under this benefit plan that are part of a clinical trial or research study approved by an Institutional Review Board as well as medically necessary services to treat complications arising from participation in the clinical trials.
    - **NOTE:** These services must be prior authorized by the Health Plan and all plan limitations apply.

- Diabetic treatment, equipment, supplies, and education:
  - Includes blood glucose monitors, monitor supplies, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics, and outpatient self-management training and education.
    - **NOTE:** Some services are provided under the member's pharmacy benefit. Copays may apply.

- Gender transition services:
  - Coverage related to gender affirming services that otherwise fall within the beneficiary's scope of covered CHIP benefits (e.g., physician's services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies etc.) will be compensable under the CHIP program when determined medically necessary. Sex specific health care cannot be denied or limited because the person seeking services identifies as belonging to another gender.
    - **NOTE:** Some services may require prior authorization.

- Imaging studies, including,
  - X-rays and sonograms
  - Advanced imaging services, such as MRIs, CT scans, and PET scans
    - **NOTE:** Some services may require preauthorization.

- Laboratory tests
  - Includes all laboratory services related to the diagnosis and treatment of sickness and injury provided on an inpatient or outpatient basis when ordered by a participating provider or referred specialist and/or facility provider.
    - **NOTE:** Some services may require a preauthorization.

- Maternity education and services, including:
  - Breast-feeding classes
  - Breast pumps
  - Childbirth education for Lamaze I and Lamaze refresher classes
  - Parenting education

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- Medical nutritional therapy:
  - Provided by a dietitian or facility-based program, when ordered by a physician for certain diagnoses to treat chronic illness or conditions.
    - **NOTE:** No limits.

- Medical therapy services, including:
  - Chemotherapy
  - Dialysis
  - Infusion therapy
  - Radiation therapy
  - Respiratory therapy

- Nutritional counseling:
  - Provided by a dietitian or facility-based program, when ordered by a physician for any diagnosis

- Occupational, physical, and speech therapy:
  - Habilitative therapy (benefit limits are combined with limits for regular occupational, physical, and speech therapy visits)
    - **NOTE**: Limited to **60 visits** per therapy type **per plan year.**

- Pain management

- Tobacco cessation counseling:
    - **NOTE**: Up to **50 visits per plan year.**

- Voluntary sterilization

Prescription Drug Coverage

UPMC *for Kids* provides coverage for prescription drugs and some over-the-counter drugs with a physician's prescription. Generic drugs will be automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicates that the brand-name drug is medically necessary after review by UPMC *for Kids*. UPMC *for Kids* allows the brand-name drug at the generic cost-sharing rate if deemed necessary by the provider. Some members have copayments for covered drugs. Members must use a pharmacy participating in the UPMC *for Kids* pharmacy network.

➢ See *UPMC for Kids Pharmacy Program drug benefit information*, Pharmacy Services, Chapter J.

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Routine Vision Benefits

Envolve Vision administers routine vision benefits for UPMC *for Kids* members. Members must use a participating Envolve Vision provider. Members may self-direct care.

Vision benefits include:

- **One** routine eye exam **once in a 12-month period**, unless an additional exam is medically necessary
- **One pair** of prescription lenses and **one** frame, unless a second frame is medically necessary, or contact lenses (including lens fitting)
- Replacement of broken, lost, or scratched corrective lenses, frames, or medically necessary contacts (when replacement is deemed medically necessary), not to exceed **two prescriptions per year.**
- Lenses
  - **One pair** of standard lenses are covered in full **every calendar year**.
  - Additional charges may apply for nonstandard lenses. Such charges are the responsibility of the member.
  - Contact lenses and frames allowance of $130 for prescription lenses and frames or contact lenses (including the lenses fitting).
  - Charges exceeding the $130 allowance are the responsibility of the member. For any amount over $130, a 15% discount applies for contact lenses and a 20% discount applies for frames.

Providers and members may call **Envolve Vision** directly at **1-866-921-7965** from 8 a.m. to 8 p.m., Monday through Friday.

Closer Look at Vision Benefits for a Medical Condition

UPMC *for Kids* covers prescription lenses and frames, or the fitting and adjustment of contact lenses in full.

➢ **NOTE**: If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus, or aphakia a copayment may apply.

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Urgent Care Visits

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

- **NOTE:** Some members have a copayment for urgent care visits, which is the same as the copayment for a specialist visit.

Out-of-Area Urgent Care

Coverage is provided if a member is traveling outside the UPMC *for Kids'* service area and has an urgent medical condition that requires medical attention before returning to the area. An urgent medical condition is any illness, injury, or severe condition which, under reasonable standards of medical practice, would be diagnosed and treated within a **24-hour period** and, if left untreated, could rapidly become a crisis or emergency medical condition.

This includes situations in which a person's discharge from a hospital would be delayed until services are approved or in which a person's ability to avoid hospitalization depends upon prompt approval of services. Routine care is not covered outside the UPMC *for Kids'* service area. Some members have a copayment for out-of-area urgent care visits, which is the same as the copayment for a specialist visit.

Women's Care

Benefits for women's preventive care include an annual Pap test, annual gynecological exam, and clinical breast examination from a network provider. UPMC *for Kids* members may also go to a participating obstetrician-gynecologist for all other medically appropriate covered obstetrical and gynecological care including outpatient services and inpatient admissions.

A referral from the PCP is not required for members to see a participating obstetrician-gynecologist. However, obstetrician-gynecologists are encouraged to coordinate care with the member's PCP.

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Benefit Exclusions

Services Not Covered

The following is a list of the products, services, and procedures that are generally excluded from UPMC *for Kids* benefits. A complete listing of UPMC *for Kids* benefit exclusions is available online at **www.upmchealthplan.com**.

- Alternative medicine (examples: acupuncture, massage therapy, and yoga)
- Any services, supplies, or treatments not specifically listed in this handbook as a covered benefit or service
- Assisted fertilization
- Comfort or convenience items such as air conditioners or exercise equipment
- Cosmetic surgery, except post-mastectomy breast reconstruction
- Certain drugs – Drug Efficacy Study Implementation (DESI), experimental drugs, weight loss, infertility, and drugs used for cosmetic reasons as well as lost, stolen, or destroyed medications
- Charges for completing forms or missed appointments
- Court-ordered services when not medically necessary or appropriate
- Custodial care
- Experimental and investigational procedures, treatment, equipment, drugs, and devices
- Experimental or investigative transplants/organ donations
- Food supplements
- Home care services for chronic conditions requiring long periods of care or observation, dietary services, homemaker services, or custodial care
- Intellectual disability services
- Long-term care
- Medically unnecessary services
- Motor vehicle accident and workers' compensation-related services when payable under these conditions
- Nonemergency transportation
- Non-medical items
- Non-prescription glasses or contact lenses
- Nutritional supplements
- Out of country care (Emergency and routine care provided outside the United States. United States is defined to include the District of Columbia, Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.)
- Pregnancy termination services, except those provided for under the Commonwealth of Pennsylvania laws
- Services provided without the required prior authorization
- Services by non-participating providers unless prior authorization was obtained.
- Services to treat temporomandibular joint syndrome (TMJ) with the exception of surgery for temporomandibular joint disease
- Third-party physical evaluations and examinations primarily to meet a requirement of schools, sports, camps, or driver's license
- Weight reduction surgery

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Member Complaint and Grievance Procedures

What is a Complaint?

A Complaint is filed when a member's parent or guardian is dissatisfied with services a member received from UPMC *for Kids* or their provider, payment of services, or benefit structure. If the First Level Complaint disputes one of the following, the member must file a Complaint within **60 calendar days** from the date the incident occurred or the date the member receives written notice of the decision:

- A denial because the service or item is not a covered service
- The failure of UPMC *for Kids* to provide a service or item in a timely manner
- The failure of UPMC *for Kids* to decide a Complaint or Grievance within the specified time frames
- A denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in CHIP;
- A denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the member; or
- A denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

> ➢ **NOTE**: For **all other** Complaints, there is no time limit for filing a First Level Complaint.

What Should a Member's Parent or Guardian Do if He or She Has a Complaint?

Parents or guardians should call the **UPMC *for Kids* Health Care Concierge team** at **1-800-650-8762 (TTY 711).** Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.**,** or write to:

UPMC *for Kids*
Complaint and Grievance Department
PO Box 2939
Pittsburgh, PA 15230-2939

Parents or Guardians who do not speak English as their primary language should call the **UPMC *for Kids* Health Care Concierge team** at **1-800-650-8762 (TTY 711)** to be connected with a contracted language translation services representative.

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The member's parent or guardian may appoint a representative in writing at any time. The representative will act on their behalf when filing a Complaint. The member's parent, guardian, or representative may also request the aid of a UPMC Health Plan employee who has not participated in the previous decision to deny coverage. Members with disabilities may receive accessibility assistance at no cost to the member. If a provider is filing on behalf of a member, with the member's written consent, the request must include certain information, statements, and signatures.

➢ See *Member's Written Consent Guidelines*, Grievance section , UPMC *for Kids*, Chapter D.

UPMC *for Kids* will investigate and review the Complaint. Parents or guardians of members and/or their appointed representative, will have **seven days** advance notice of the date and time of the review meeting. Parents or guardians have the right to meet with the First-Level Committee in person, by telephone, or by video conference. The First-Level Review is conducted within **30 calendar days** from the receipt of the request for a First-Level Complaint. A member's parent or guardian will be notified by mail within **five business days** after the First-Level Complaint Committee reaches a decision. The member's parent or guardian may request to extend the decision time frame by up to **14 days**.

What if a Member's Parent or Guardian is Still Unhappy with the Decision?

A member's parent or guardian who is unhappy with the First-Level Complaint decision has options to continue the complaint process.

If the Complaint disputes one of the following, the member may file a request for an External Review:

- A denial because the service or item is not a covered service
- The failure of UPMC *for Kids* to provide a service or item in a timely manner
- The failure of UPMC *for Kids* to decide a Complaint or Grievance within the specified time frames
- A denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in CHIP
- A denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the member; or
- A denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The request for an External Review must be filed within **15 calendar days** from the mail date on the written notice of the First-Level Complaint decision. A request for an External Review must include certain information.

➢ See ***What Can a Member's Parent or Guardian Do if He or She Does Not Like the Decision of the Second-Level Committee?*** for more information about requesting an External Review. UPMC *for Kids*, Chapter D.

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For all other Complaints, the member's parent or guardian may make a Second-Level Complaint with UPMC *for Kids*. That complaint must be filed within **45 calendar days** from the date the member's parent or guardian receives written notice of the First-Level Complaint decision. Parents or guardians of members and/or their appointed representative, will have **15 days** advance notice of the date and time of the review meeting. Parents or guardians have the right to meet with the Second-Level Committee in person, by telephone, or by video conference. The Second-Level Review is conducted within **45 calendar days** from the receipt of the request for a Second-Level Complaint. A member's parent or guardian will be notified by mail within **five business days** after the Second-Level Complaint Committee reaches a decision.

What Can a Member's Parent or Guardian Do if He or She Does Not Like the Decision of the Second-Level Committee?

Parents or guardians have **15 calendar days** from receiving UPMC *for Kids*' decision letter to file for an External Complaint Review to either the Pennsylvania Department of Health or the Pennsylvania Insurance Department.

A request for External Review must include the following information:

- The member's name, address, and daytime telephone number
- The member's UPMC *for Kids* identification number
- The name of the member's CHIP plan (UPMC *for Kids*)
- A brief description of the issue; and
- A copy of the Second-Level Review decision notice

Complaints must be sent in writing to either:

PA Department of Health
Bureau of Managed Care
Health & Welfare Building
Room 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787
TTY: 1-800-654-5984
Fax: 1-717-705-0947

or

Pennsylvania Insurance Department
Bureau of Customer Service
Room 1209 Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone: 1-877-881-6388

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What Is a Grievance?

A Grievance is filed when a member's parent or guardian is unhappy about UPMC *for Kids*' decision to:

- Fully or partially deny payment based on medical necessity.
- Approve a requested service at a lesser level or for a period of time that is different from what was requested.
- Approve payment for a service different from the service requested.

How Does a Member's Parent or Guardian Initiate a Grievance?

When UPMC *for Kids* issues a denial, decreases a service, or approves a service different from the service requested, a member's parent or guardian will receive a letter informing him or her about the grievance process. The parents or guardians have the right to participate in the Grievance process.

A member's parent or guardian must file a Grievance within **60 calendar days** from the date they receive written notice of the decision. Parents or guardians may send a Grievance letter or call the **UPMC *for Kids* Health Care Concierge team** at **1-800-650-8762 (TTY 711),** Monday through Friday from 7 a.m. to 7 p.m., and Saturday from 8 a.m. to 3 p.m. Parents and guardians who do not speak English as their primary language should call **UPMC *for Kids* Health Care Concierge team** at **1-800-650-8762** to be connected with a contracted language translation services representative.

The member's parent or guardian may appoint a representative in writing at any time. The representative will their behalf when filing a Grievance. The member's parent, guardian, or representative also may request the aid of a UPMC Health Plan employee who has not participated in the previous decision to deny coverage.

In addition, providers may, with the parent, guardian, or member's written consent, file a Grievance on a member's behalf. Providers may request the parent, guardian, or member's written consent at the time of a treatment or service; however; the provider cannot make the parent, guardian, or member sign as a condition of providing that care.

After receiving member consent, providers must file a Grievance within **10 days** upon receipt of the UPMC *for Kids* denial.

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Member's Written Consent Guidelines

If a member requests that a provider file a Grievance, the member must complete a consent form or write a letter. The consent form or letter of consent must include certain information, statements, and signatures that are required by the Pennsylvania Department of Health.

Required Information

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

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

Required Statements

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

- "The member or member's representative may not submit a Grievance concerning the services listed in this letter of consent or consent form unless the member or member's representative rescinds consent in writing. The member or member's representative has the right to rescind consent at any time during the grievance process."
- "The consent of the member or member's representative shall be automatically rescinded if the provider fails to file a Grievance."
- "The member or member's representative has read this consent form and has had it explained to his or her satisfaction."

Required Signatures

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

- The dated signature of the member or the member's representative
- The dated signature of a witness

The grievance should be sent to:

UPMC *for Kids*
Complaint and Grievance Department
PO Box 2939
Pittsburgh, PA 15230-2939

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Alert – No Duplicate Complaints or Grievances

The member's parent or guardian, member's representative, and his or her provider may not each file a separate complaint or grievance for the same issue.

Parents or guardians of members and/or their appointed representative, will have **15 calendar days** advance notice of the date and time of the review meeting. Parents or guardians have the right to meet with the Grievance committee in person, by telephone, or by video conference. The Grievance review is conducted within **30 calendar days** from the receipt of the request for a Grievance. A member's parent or guardian will be notified of the outcome by mail within **five business days** after the Grievance committee reaches a decision. The member's parent or guardian may request to extend the decision time frame by up to **14 calendar days**.

External Grievance Procedure

After a member's parent or guardian exhausts the Internal Grievance process, they may request an External Grievance through the Pennsylvania Department of Health by sending a letter to the UPMC *for Kids* Complaints and Grievances Department at:

UPMC *for Kids*
Complaint and Grievance Department
PO Box 2939
Pittsburgh, PA 15230-2939

Parents or guardians must ask for an External Grievance within **15 calendar days** of receiving a letter from UPMC *for Kids* about a Grievance decision.

UPMC *for Kids* will confirm receipt of the External Grievance request within **five business days** by notifying the member's parent or guardian, the member's representative or provider, if applicable, and the Department of Health, if appropriate.

The Department of Health (DOH) will randomly assign a certified review entity (CRE) to conduct the review. If DOH fails to select a CRE within **two business days**, UPMC *for Kids* may designate a CRE from a list approved by DOH. The CRE will contact UPMC *for Kids* and the member's parent or guardian or the member's representative or provider, if applicable. If desired, the member can send the reviewer any additional information the member feels would help his or her case.

The CRE will notify the member's parent or guardian in writing of the decision within **60 calendar days** of filing the External Grievance. The member's parent or guardian, the member's representative, or the provider, if applicable, may appeal the decision to a court of competent jurisdiction within **60 calendar days** of receiving the External Grievance decision.

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Expedited Complaints and Grievances

If a provider believes the usual time frames for deciding a member's Complaint or Grievance will harm the member's health, the member's parent or guardian can call the **UPMC *for Kids* Health Care Concierge team** at **1-800-650-8762,** Monday through Friday from 7 a.m. to 7 p.m., and Saturday from 8 a.m. to 3 p.m. to request that the Complaint or Grievance be expedited. Alternatively, they may send a letter to:

UPMC *for Kids*
Complaint and Grievance Department
PO Box 2939
Pittsburgh, PA 15230-2939

The expedited review follows all requirements of the typical review process, with shortened time frames because the member's health is at immediate risk.

Alert - Expedited Complaint or Grievance Process

For an expedited Complaint or Grievance, the provider must indicate in writing that a member's life or health is at risk. The provider certification must be received within **72 hours** of the request for expedited review. UPMC *for Kids* will call and send a letter within **48 hours** informing the member's parent or guardian of its decision.

Expedited External Review

Upon receipt of the Expedited Internal review decision, a member's parent or guardian may request an Expedited External Review within **15 calendar days** from the date the decision was mailed. Similar to the External Grievance process outlined above, a Certified Review Entity (CRE) will conduct the External Review and notify the member's parent or guardian of the decision. UPMC *for Kids* will call informing the member's parent or guardian of its decision.

A copy of the full UPMC *for Kids* Member Complaint and Grievance process can be viewed online at **www.upmchealthplan.com.**

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Member Rights and Responsibilities

The list of specific rights and responsibilities UPMC Health Plan distributes to CHIP members with UPMC *for Kids* benefits and their parents or guardians is as follows:

Rights

- To receive information about UPMC Health Plan, its services, its programs, its practitioners and providers, and the child's rights and responsibilities
- To be treated with respect and recognition of the child's dignity and right to privacy
- To participate with practitioners in decision making regarding the child's health care
- To receive clear and complete information from the child's doctor about the child's health condition and treatment
- To participate in a candid discussion of appropriate or medically necessary treatment options for the child's condition, regardless of cost or benefit coverage
- To voice complaints, grievances, or appeals about UPMC Health Plan, the care provided, or the child's practitioner or provider
- To choose the child's practitioner or provider from the list of network providers and to receive timely care in an emergency
- To see the child's medical records, to obtain copies, and to have corrections made, if needed
- To have the child's medical information kept confidential whether it is in written, oral, or electronic format
- To make decisions about the child's treatment, including the right not to participate in research, and to refuse treatment, as long as it is understood that by refusing may cause the child's health problem to get worse or possibly become fatal
- To make recommendations regarding UPMC Health Plan's member rights and responsibilities policy
- To access, amend, restrict, request alternate communication (method or location), and receive an accounting of any disclosures of protected health information (PHI) made to persons or organizations other than the member or the parents or guardians, and for purposes other than treatment, payment, and operations (TPO)

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Responsibilities

- To provide, to the extent possible, information that UPMC Health Plan and its practitioners and providers need in order to care for the child.
- To follow plans and instructions for care that was agreed upon with the child's practitioners.
- To treat the child's doctor and other health care workers with dignity and respect, which includes being on time for appointments and calling ahead if there is a need to cancel an appointment.
- To tell the child's practitioner as much about the child's medical history as is known.
- To follow the child's provider's directions, such as having the child take the right amount of medication at the right times if agreed to do so.
- To ask questions about how to access health care services appropriately.
- To participate, to the extent possible, in understanding any health or behavioral health problems the child may have and developing mutually agreed upon treatment goals.
- To provide a safe environment for services rendered in the child or parent/guardian's place of residence.
- To pay any applicable fees.

For Provider Rights and Responsibilities:

➢ See *Provider Rights, Responsibilities, and Roles*, Provider Standards and Procedures, Chapter B

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