UPMC *for Life* (Medicare)

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At a Glance

UPMC Health Plan offers Medicare beneficiaries a line of health benefit plans called UPMC *for Life*.

These Medicare Advantage plans, formerly known as "Medicare+Choice," replace traditional Medicare coverage with managed care options.

UPMC *for Life* HMO and PPO offer choices for more enhanced services and care options than are available through traditional Medicare, including routine vision care.

HMO Members must select a primary care provider, or PCP, and they must use providers, services, and facilities within the UPMC *for Life* networks. HMO Members are able to self-direct care to network specialists; however, they are encouraged to coordinate care with their PCP.

PPO Members are not required to select a PCP.

Closer Look at PPO Benefits

PPO Members are offered the same menu of benefits and services regardless of whether they use network or out-of-network providers, except routine chiropractic and podiatry visits are not covered out-of-network. PPO Members incur lower out-of-pocket costs if they use network providers and facilities

This chapter contains information providers need to know to deliver care to HMO and PPO Members enrolled in UPMC *for Life*. Because HMO and PPO Member benefits change annually, providers should go to **www.upmchealthplan.com** to get the most current information regarding a specific Member's benefits or to address other issues not covered in this manual.

Additionally, providers may call UPMC *for Life* **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

UPMC for Life HMO

UPMC *for Life* HMO Members may select from four benefit plans: UPMC *for Life* HMO, which does not offer Medicare Part D prescription drug coverage, UPMC *for Life* HMO Deductible with Rx, which is an HMO with a deductible and offers Medicare Part D prescription drug coverage, UPMC *for Life* HMO Rx, which offers Medicare Part D prescription drug coverage, and enhanced medical coverage. Employer groups may offer variations of these two latter HMO Rx plans, so coverage and Member cost-sharing can vary.

All UPMC *for Life* HMO Members must select a primary care provider, or PCP, in order to receive coverage. If a PCP is not selected, a UPMC *for Life* Member Services representative will assist in that selection. All services, whether coordinated through a PCP or self-directed, must be performed by a UPMC *for Life* network provider.

Unlike a traditional HMO, this enhanced access HMO allows Members to see specialists without a referral from their PCP. Women may self-direct care to ob-gyns for routine annual exams.

Most UPMC *for Life* HMO Members have copayments for physician office visits, emergency room visits, and pharmaceuticals. The following preventive services are covered with a $0 copayment: annual wellness exam, immunizations (e.g., flu, pneumonia, and Hepatitis B), and screening exams (mammograms, Pap and pelvic exam, prostate exam, bone mass measurement, colorectal exam, depression screening, dilated diabetic retinal eye exam, glaucoma screening, HIV screening, screening and counseling to reduce alcohol misuse, and screening for sexually transmitted infections), and smoking cessation). A separate copayment may apply if additional medical services are rendered during the same visit as a preventive screening exam.

➢ See ***Benefits and Services for HMO and PPO Members***, UPMC *for Life* (Medicare), Chapter F.

Providers should verify eligibility and copayment responsibility before the service is performed. Providers may verify Member information through Provider OnLine at **www.upmchealthplan.com/providers**, or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

➢ See ***Identifying Members and Verifying Eligibility***, Member Administration, Chapter I.

Key Points

- PCP is mandatory.
- Network providers and facilities must be used.
- Routine physicals, immunizations (please refer to the Member's benefit plan for specific immunization coverage), and annual screening exams are covered.
- Emergent care by any provider is covered if the Member believes that his or her health is in serious danger. Urgent care by any provider is covered if the Member believes that left untreated, his or her condition could rapidly become a medical emergency.
- Emergency services, urgently needed care, and emergency ambulance transportation may incur copayments. Only copayments for emergency services and urgently needed care are waived if the Member is admitted to a facility within **three days** for the same condition. The emergency ambulance transportation copayment is not waived.

➢ See ***Emergency Care for Emergency Department and Emergency Transportation***, UPMC *for Life* (Medicare), Chapter F.

Closer Look at Self-Directed Care

Nonemergent, self-directed care by out-of-network specialists is not covered unless prior authorization is obtained through **Utilization Management.** Provider must contact Utilization Management by submitting a request for prior authorization through Provider OnLine at **www.upmchealthplan.com/providers,** or by calling **Utilization Management** at **1-800-425-7800** from 8 a.m. to 4:30 p.m., Monday through Friday.

UPMC for Life PPO

UPMC *for Life* PPO Members do not select a primary care provider, or PCP, in order to receive coverage but it is preferred that they do. PPO Members are offered the same menu of benefits and services regardless of whether they use network or out-of-network providers. PPO Members incur lower out-of-pocket costs if they use UPMC *for Life* network providers and facilities.

Members may select from two benefit levels: UPMC *for Life* PPO High Deductible with Rx, which is a PPO with a deductible and offers Medicare Part D prescription drug coverage, and UPMC *for Life* PPO Rx Enhanced, which offers Medicare Part D prescription drug coverage and enhanced medical coverage. Employer groups may offer variations of these plans, so coverage can vary.

The following preventive services are covered with a **$0 copayment** when using a network provider: annual wellness exam, immunizations (e.g. flu, pneumonia, and Hepatitis B), and screening exams (mammograms, Pap and pelvic exam, prostate exam, bone mass measurement, colorectal exam, depression screening, dilated diabetic retinal eye exam, glaucoma screening, HIV screening, screening and counseling to reduce alcohol misuse, and screening for sexually transmitted infections) and smoking cessation. A separate copayment may apply if additional medical services are rendered during the same visit as the preventive screening exam. Members receiving preventive services out-of-network may have a higher cost-share amount.

UPMC *for Life* PPO Members may have copayments for physician office visits, emergency department visits, or pharmaceuticals when care is received within the UPMC *for Life* network. Members may have deductibles, copayments, or coinsurance when care is received outside the UPMC *for Life* network. UPMC *for Life* PPO High Deductible with Rx Members have a deductible and may have either a copayment or coinsurance for in-network or out-of-network services.

Providers should verify eligibility as well as deductible, copayment, or coinsurance responsibility before the service is performed. Providers may verify Member information through Provider OnLine at **www.upmchealthplan.com**, or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762**.

➢ See ***Identifying Members and Verifying Eligibility***, Member Administration, Chapter I.

Key Points

Network Care:

- Members have lower out-of-pocket costs (e.g., copayments and coinsurance) when using network providers and facilities.
- Annual deductibles, copayments, maximum limits, and coinsurance may apply.
- Routine physicals, immunizations (please refer to the Member's benefit plan for immunization coverage), and annual screening exams are covered.

Out-of-Network Care:

- Members have higher payments for out-of-network providers or services.
- Annual deductibles, copayments, maximum limits, and coinsurance may apply.
- Routine preventive services are covered out-of-network; however, applicable deductibles, copayments, or coinsurance limits may apply.
- Members may be responsible for the difference between the provider's charges and UPMC Health Plan's payment (reasonable and customary amount).

Emergency Services:

- Emergent care by any provider is covered if the Member believes that his or her health is in serious danger.
- Urgent care by any provider is covered if the Member believes that left untreated, his or her condition could rapidly become a medical emergency.
- Emergency services, urgent care services, and emergency ambulance transportation incur copayments. Only copayments for emergency services and urgently needed care are waived if the Member is admitted to a facility within **three days** for the same condition. The emergency ambulance transportation copayment is not waived.

➢ See ***Emergency Care for Emergency Department and Emergency Transportation***, UPMC *for Life* (Medicare), Chapter F.

UPMC Health Plan Medicare Supplement

UPMC Health Plan offers two types of Medicare Supplement plans. A Medicare Supplement plans allows a Member to see any provider for professional and facility services. A Medicare Select plan is a type of Medicare supplement plan that has a provider network limitation. The UPMC Health Plan Medicare Select plan allows Members to see any professional provider, but they must use the UPMC *for Life* facility network in order to have facility services and treatments covered.

Traditional Medicare is the primary payer for Medicare supplement plans, and all claims must be submitted to Medicare first. Medicare Supplement plans will receive the claim after traditional Medicare has paid its portion. Providers should verify eligibility and Member cost-sharing responsibility before the service is performed.

UPMC Health Plan's Medicare Supplement product offers three standard plans: A, B, and F. The Medicare Select product offers four standard plans: A, B, C, and H. Each plan offers a different combination of benefits for Members, who can select the plan most appropriate for their health care
needs.

Figure: F.1

Covered Benefits	Plan A	Plan B	Plan F
• Part A Hospital Stay Deductible		●	●
• Copayment for **Days 61-150** in a Hospital	●	●	●
• Coverage for an Additional **365 Days** in a Hospital	●	●	●
• Part B Medical Deductible			●
• Part B Medical Coinsurance	●	●	●
• Part A & B Blood Deductible	●	●	●
• Part B Excess Charges			●
• Skilled Nursing Facility Coinsurance			●
• Foreign Travel			●

Benefits and Services for HMO and PPO Members

Covered Benefits

UPMC *for Life* Members receive all the benefits offered by traditional Medicare as well as additional benefits.

Although the covered services for HMO and PPO Members generally are identical, HMO Members must use UPMC *for Life* network providers, and HMO Premier Members must use UPMC *for Life* Premier network providers. PPO Members may use out-of-network providers and facilities at higher out-of-pocket costs. Some benefits and services require authorization.

A provider may bill a UPMC *for Life* Member for a non-covered service or item only if, the provider requested a prior authorization and received a denial and an Integrated Denial Notice (IDN) before performing the service.

➢ See ***Integrated Denial Notice***, UPMC *for Life*, Chapter F.

The provider must also inform the Member:

- Of the nature of the service;
- That the service is not covered by UPMC *for Life*, and UPMC *for Life* will not pay for the service; and
- Of the estimated cost to the Member for the service.

Providers should refer to Provider OnLine at **www.upmchealthplan.com/providers** for detailed information about a Member's specific benefits and possible service limitations.

Integrated Denial Notice

If a UPMC *for Life* and/or UPMC *for Life* Dual 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 **www.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 Protections, 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 ***Integrated Denial Notice***, Provider Standards and Procedures, Chapter B.
    - ➢ See ***Covered Benefits and Services***, UPMC Medicare Special Needs Plans, Chapter M.

Ancillary Services

Utilization Management can assist providers with the coordination of complex ancillary services, such as the following, by accessing Provider OnLine at **www.upmchealthplan.com/providers.**

- Chiropractic care
- Diagnostic services (e.g., lab, x-ray), including special diagnostics
- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides; and registered dietitian services)
- Home infusion therapy
- Home medical equipment (HME), including custom wheelchairs and rehabilitation equipment
- Hospice care
- Laboratory services
- Non-emergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Respiratory equipment, including oxygen therapy

➢ **NOTE:** Copayments or coinsurance may apply.

Chiropractic Care

Manual manipulation of the spine to correct subluxation, which is the chiropractic coverage offered by traditional Medicare, is available to all UPMC *for Life* members. Children **under the age of 13** require prior authorization for chiropractic services.

For HMO Members: These services do not have to be coordinated by a Member's PCP but must be performed by network providers. In addition to manual manipulation of the spine to correct subluxation, some HMO plans give Members coverage for routine chiropractic visits, which is a benefit not covered by traditional Medicare. Copayments apply, and some plans have visit limitations for routine chiropractic care. Providers should verify the Member's benefits to determine which Members have this enhanced benefit.

For PPO Members: Medicare-covered benefits do not need to be coordinated or performed by network providers. Copayments apply for care performed by network providers. Copayments and deductibles may apply for care performed by out-of-network providers. Member costs may be higher for out-of-network care. In addition to manual manipulation of the spine to correct subluxation, some PPO plans give Members coverage for routine chiropractic visits, which is a benefit not covered by traditional Medicare.

Dental Services

In general, preventive dental benefits (such as cleaning) are not covered for HMO or PPO Members. Some employer group plans may provide limited dental coverage. Please refer to Provider OnLine at **www.upmchealthplan.com/providers** or call **UPMC Health Plan's Interactive Voice Response (IVR)** system at **1-866-406-8762.**

Diagnostic Services

Diagnostic services include x-rays, laboratory services, and tests. All UPMC *for Life* Members need a prescription for any diagnostic service.

Prior-authorization, deductible, copayments, and/or coinsurance may apply to high-technology x-ray services (CT, MRA/MRI, PET scan, nuclear medicine, etc.).

UPMC *for Life* PPO Members may use out-of-network providers or facilities for higher out-of-pocket costs. Some PPO Members may have to satisfy a deductible and/or coinsurance.

Emergency Care

Emergency department care typically requires a copayment, which is waived if the Member is admitted to the hospital within **three days** for the same condition.

HMO Members should notify their PCP within **24 hours** or as soon as reasonably possible after receiving the emergency service.

Closer Look at Emergency Care

The hospital or facility must contact **Utilization Management** within **48 hours** or on the **next business day** after the emergency admission.

Providers must contact **Utilization Management** by submitting a request for prior authorization through Provider OnLine at **www.upmchealthplan.com/providers** or by calling **1-800-425-7800**.

Alert—Emergency Care

All Members, if they believe that they are experiencing a true medical emergency may utilize any emergency department or office. Out-of-network care for emergencies, including ambulance services, is covered.

Emergency Transportation

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

Alert— Emergency Ambulance Transportation

In the case of a life-threatening emergency, Members should **dial 911** or their local emergency service. Emergency transportation **does not require** a referring provider to coordinate the service.

Nonemergency Transportation

Nonemergency medically necessary medical transportation may be covered if coordinated by the referring provider through **UPMC Medical Transportation** at **1-877-521-RIDE (7433).**

All requests for medically necessary nonemergency medical transportation must be coordinated by the referring provider for the following:

- Air ambulance
- Ground ambulance
- Invalid coach (i.e., stretcher van)
- Wheelchair van transportation

Hearing Services

Diagnostic hearing exams are available to all UPMC *for Life* HMO and PPO Members. The UPMC *for Life* HMO Rx Enhanced plan, the UPMC *for Life* PPO Rx Enhanced plan, and some employer group plans include a diagnostic hearing exam, a routine hearing test, and fitting evaluation for a hearing aid.

Copayments may apply for network services. Allowance and limitations for hearing aids vary by plan.

PPO Members may use out-of-network providers. Some PPO Members may have to satisfy a deductible, and copayments, and/or coinsurance may apply.

Inpatient Hospital Care

Inpatient hospital care requires authorization before admission, except in an emergency. Providers must contact **Utilization Management** by submitting a request for prior authorization through Provider OnLine at **www.upmchealthplan.com/providers**.

For PPO plan Members, while prior authorization is not required for out-of-network, nonemergency hospital admissions, providers are encouraged to obtain it. Providers who want to obtain a prior authorization for a PPO plan Member must contact Utilization Management to authorize admissions **within 48 hours** or on the next business day by submitting a request through Provider OnLine at **www.upmchealthplan.com/providers**.

UPMC *for Life* Members are covered for **unlimited days** in each benefit period.

HMO Members have copayments for each hospital admission. Members in the UPMC *for Life* HMO Deductible with Rx plan may have a deductible if the annual deductible was not met.

Some PPO Members have copayments for each admission to a UPMC *for Life* network hospital and applicable deductibles and/or coinsurance may apply for out-of-network admissions.

Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder benefits are managed through UPMC Health Plan Behavioral Health Services (BHS), which provides triage and referral for emergency care **24 hours a day, 7 days a week.**

Providers may call **BHS** at **1-866-441-4185.**

Members may call **BHS** at **1-888-251-0083, (TTY: 711).**

Key Points

- Inpatient care may require a copayment even if services are performed in a network hospital. Members have a lifetime limit of **190 days** in a psychiatric hospital.
- Outpatient mental health and substance use disorder services may require a deductible, copayments, and/or coinsurance for individual therapy or group therapy.
- Members may self-refer their behavioral health services to BHS network providers. Behavioral health providers must coordinate a UPMC *for Life* Member's care directly with **BHS** at **1-866-441-4185.**
- PCPs may contact BHS directly for help finding a network provider for a Member.
- Only BHS may authorize behavioral health services.

Office Visits

Visits to physicians, specialists, nurse practitioners, physician assistants, chiropractors, podiatrists, or other participating health care professionals may require a deductible, copayment and/or coinsurance.

Outpatient Rehabilitation Therapy

Rehabilitation therapy includes physical therapy, speech and language therapy, occupational therapy, and cardiac/pulmonary therapy. A copayment may apply for services provided on an outpatient basis. Members in the UPMC *for Life* HMO Deductible with Rx plan may have a deductible if the annual deductible was not met. There are no therapy limits for services performed by network providers for the UPMC *for Life* HMO and PPO plans.

PPO Members may have to satisfy a deductible, copayment, and/or coinsurance. Providers should verify the Member's eligibility for this benefit at **www.upmchealthplan.com/providers** or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

Outpatient Surgery

Outpatient surgical procedures performed either at an ambulatory surgical center or at an outpatient hospital facility may require a copayment. An office-visit copayment may apply when surgical procedures are performed in a provider's office. PPO Members and Members enrolled in the UPMC *for Life* HMO Deductible with Rx plan also may have to satisfy a deductible, copayment, and/or coinsurance.

Podiatric Care

Some UPMC *for Life* Members have routine podiatric coverage beyond that provided by traditional Medicare, which includes care for medical conditions affecting the lower limbs, such as diabetes and peripheral vascular disease.

A copayment may apply for care by network providers. PPO Members may use out-of-network providers for medical conditions affecting the lower limbs; however, PPO Members may have to satisfy a deductible, and copayments and/or coinsurance may apply.

Individual podiatric benefits may be verified at **www.upmchealthplan.com/providers** or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

Closer Look at Orthotics and Prosthetics

A network podiatrist may supply orthotics or prosthetics to UPMC *for Life* Members only if the podiatrist is also credentialed as a home medical equipment (or HME) provider. When supplied by a provider who is not contracted as an HME provider, these items will not be reimbursed by UPMC Health Plan, and the Member will not be responsible for any charges.

Prescription Drug Coverage

All Members of UPMC *for Life* have some limited drug coverage as required by Medicare through Medicare Part B. Medicare Part D drug benefits depend on the type of UPMC *for Life* coverage.

Members with UPMC *for Life* HMO have only medical coverage through Parts A and B with UPMC Health Plan. In addition to the Member's medical coverage, a limited number of drugs mandated by the Centers for Medicare & Medicaid Services (CMS) are covered. These are the prescription drugs typically covered by traditional fee-for-service Medicare (referred to as Part B drugs).

With the UPMC *for Life* Prescription Drug Plan, Members are required to pay the copayment amounts for medications until the total cost (the total amount the Member paid as well as the amount the UPMC *for Life* Prescription Drug Plan has paid) reach $2,850. Members then receive a discount on brand-name drugs and pay 72% of the plan's costs for all generic drugs until their **yearly** out-of-pocket drug costs reach $4,550. After reaching $4,550, Members generally pay a $2.55 copayment for generic and preferred brand drugs that are multi-source and $6.35 for all other drugs, or a 5% coinsurance, whichever is greater.

Members who have UPMC *for Life* HMO Deducible with RX, UPMC *for Life* HMO Rx, UPMC *for Life* HMO Rx Enhanced, UPMC *for Life* PPO High Deductible with Rx, or the UPMC *for Life* PPO Rx Enhanced plan have coverage for formulary outpatient prescription drugs and Part A and B Medicare coverage, including Part B medications.

➢ See ***UPMC for Life outpatient prescription drug benefit***, Pharmacy Services, Chapter J.

Providers also may check a Member's benefits online at **www.upmchealthplan.com/providers** or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

Skilled Nursing Facility

UPMC *for Life* **does not** require a **three-day** hospital stay before admission to a skilled nursing facility (SNF). This permits a Member to be admitted to a SNF directly from the emergency department, from home, or from a brief inpatient stay, as long as the care is medically appropriate.

Providers must **contact Utilization Management,** to obtain prior authorization for skilled nursing facility admissions, by submitting a request through **Provider OnLine** at **www.upmchealthplan.com/providers**. Failure to obtain authorization for this service can result in significantly higher costs.

A copayment may apply. Care in a network skilled nursing facility has a benefit period of up to **100 days**, which is calculated just as in traditional Medicare. PPO Members may use out-of-network skilled nursing facilities, also with a benefit period of up to **100 days**, but the Member will have increased out-of-pocket expenses.

➢ See ***Closer Look at Benefit Periods***, UMPC *for Life* (Medicare), Chapter F.

Benefits for specific Members may be verified at **www.upmchealthplan.com/providers** or by calling UPMC Health Plan's **Interactive Voice Response (IVR) system** at **1-866-406-8762.**

Closer Look at Benefit Periods

A benefit period begins the day the UPMC *for Life* Member is admitted to a hospital or skilled nursing facility and ends when the Member has been discharged for at least **60 consecutive days**. If the Member is admitted to a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods a UPMC *for Life* Member may have

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.

A copayment may apply. Members do not have a copayment if admitted to the hospital within **three days** with the same condition.

Routine Vision Services

Routine Vision benefits are provided by **UPMC Vision Care**. HMO and PPO Members have a routine vision allowance toward the cost of one routine eye exam and eyewear (does not include lens options –such as tints, progressives, transition lenses, polish, and insurance) **every two years**. The services may be received from plan providers (UPMC Vision Care) or non-plan providers. Members may have to pay out-of-pocket and then submit a claim for payment of services provided by non-plan providers.

For UPMC *for Life*, providers and Members may call **UPMC Vision Care** directly at

Providers may call: **1-877-539-3080.**

Members may call: 1**-877-262-7870, (TTY: 711).**

Closer Look at Cataract Surgery

Care for diagnosis and treatment of eye diseases and conditions, including eyewear following cataract surgery, is provided through the medical benefits for UPMC *for Life* Members. The glaucoma screening is also provided under the medical benefits and is considered a preventive screening so there is no Member cost-sharing when performed by a network provider

Services Not Covered

The following services are not covered under UPMC *for Life* plans:

- Alternative medicine and therapies, including acupuncture
- Conditions covered through other programs
  (e.g., military service, workers' compensation, and motor vehicle insurance)
- Experimental/investigative treatments and surgical procedures
- Over-the-counter treatments
- Non-medically necessary treatment (e.g., cosmetic surgery)
- Optional programs, unless provided through a health management program
  (e.g., weight control)
- Private duty nursing and custodial care

Services Requiring Prior Authorization

The following services require prior authorization:

- Inpatient hospital care, except in an emergency
- Inpatient mental health care, except in an emergency
- Outpatient mental health care
- Select advance imaging services
- Select durable medical equipment
- Select home health care services
- Select outpatient surgery services
- Select Part B drugs
- Skilled nursing facility care, except in an emergency

Providers must contact Utilization Management by submitting a prior authorization request through **Provider OnLine** at **www.upmchealthplan.comp/providers**.

Member Appeals and Grievances

Appeals

All UPMC *for Life* Members have the right to appeal any decision regarding payment or the failure to approve, furnish, arrange for, or continue what the Member believes are covered services.

Members also may appeal any denial of payment for services that they believe UPMC *for Life* is required to pay (including non-Medicare-covered benefits). Members may file an appeal or have someone else (Representative) file the appeal for them.

HMO and PPO Members should contact the **UPMC *for Life* Health Care Concierge team** at **1-877-539-3080 (TTY: 711),** Monday through Friday, from 8 a.m. to 8 p.m., or Saturday from 8 a.m. to 3 p.m., to discuss the appeal process. Members who do not speak English as their primary language should contact the **Health Care Concierge team** at **1-877-539-3080**, where they will be connected with a contracted language-translation services representative.

Appointing an Authorized Representative

Members may appoint a family member, friend, physician, or attorney to act as their authorized representative by completing the Appointment of Representative form or other equivalent written notice following the steps below. Members may obtain forms by calling the **UPMC *for Life* Health Care Concierge team** at **1-877-539-3080 (TTY: 711)**. Members who do not speak English as their primary language should contact the **Health Care Concierge team** at **1-877-539-3080**, where they will be connected with a contracted language-translation services representative.

The Appointment of Representative form is also available on the UPMC Health Plan website at **www.upmchealthplan.com** in the Medicare section.

1. **Include the name, address, and telephone number of the Member**

2. **Include the Member's HICN (Medicare number)**

3. **Include the name, address, and telephone number of the individual being appointed**

4. **Contain a statement appointing an individual as the Member's authorized representative**.
    - For example, "I (member name) appoint (name of representative) to act as my authorized representative in requesting an appeal from UPMC *for Life* regarding the denial or discontinuation of medical services."

5. **Obtain signature of the Member.**
    - The Member must sign and date the statement.

6. Obtain signature of the Member's representative.

- The Member's authorized representative must also sign and date the statement.

7. Include the signed statement with the appeal.

- The Member must include the signed statement with the appeal.

Filing an Appeal

UPMC *for Life* accepts verbal and written requests for standard reconsideration (appeal) of services or payment that are filed within **60 calendar days** of the notice of the initial organization determination:

UPMC *for Life*
Appeals/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939
Fax: 412-454-7920
Phone: 1-877-539-3080

If UPMC *for Life* makes a fully favorable decision on an appeal, it notifies the Member and authorizes or provides the service as expeditiously as the Member's health requires, but no later than **30 calendar days** after receiving the appeal.

If UPMC *for Life* is unable to make a fully favorable decision, it forwards the case to CMS's independent review entity as expeditiously as the Member's health requires, but no later than **30 calendar days** after receiving the appeal.

UPMC *for Life* will make a decision on appeals regarding payment for services already received no later than **60 calendar days** after receiving the appeal.

Members of UPMC *for Life* have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with UPMC *for Life's* decision to deny, reduce, or terminate services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility (CORF).

The QIO will inform UPMC *for Life* and the provider of the request for a review. UPMC *for Life* may need to present additional information needed by the QIO to make a decision. The provider should be aware that he or she may need to provide additional information. Based on the expedited time frames, the QIO decision should take place by close of business of the day coverage is to end.

Alert—Expedited Appeal Procedures

An expedited appeal may be filed if the Member believes his or her life, health, or ability to regain maximum function is in immediate jeopardy and UPMC *for Life* fails to provide medically necessary covered services. The Member, his or her health care provider, or an authorized representative should call **UPMC *for Life* Health Care Concierge Team** at **1-877-539-3080 (TTY: 711)**, Monday through Friday, from 8 a.m. to 8 p.m., or Saturday from 8 a.m. to 3 p.m. and ask for an expedited appeal. Members who do not speak English as their primary language should contact the **Health Care Concierge team** at **1-877-539-3080**, where they will be connected with a contracted language-translation services representative.

UPMC *for Life* is responsible for gathering all necessary medical information relevant to the Member's request for reconsideration; however, it may be helpful to include additional information to clarify or support the request. UPMC *for Life* will make a decision about the request within **72 hours**.

Grievances

Members have the right to file a complaint or dispute — also called a grievance — about problems that include the following:

- Covered health service procedure or item that, during a course of treatment, did not meet acceptable standards for delivery of health care
- Issues such as office waiting times, difficulty getting through on the phone, quality of care or services provided, physician behavior, adequacy of facilities, or other similar Member concerns
- Involuntary disenrollment situations
- UPMC *for Life's* decision to process a request for a service or to continue a service within the standard **14-calendar day** period rather than the expedited, **72-hour period**
- UPMC *for Life's* decision to process the Member's appeal request within the standard **30-day** period rather than the expedited, **72-hour period**
- Change in premiums or cost-sharing arrangements from **one contract year** to the next

UPMC *for Life* attempts to resolve these and other issues over the telephone, especially if they are due to misinformation, a misunderstanding, or a lack of information; however, if a Member's concerns cannot be resolved in this manner, a more formal Member grievance procedure is available. In this case, the grievance should be communicated in writing or by phone to Member Services. Within **30 days** after receipt of the grievance, UPMC *for Life* will inform the Member in writing how the dispute has been resolved.