UPMC for Life (Medicare)

At a Glance

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

These Medicare Advantage plans 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 supplemental benefits such as fitness services, routine dental, routine vision, and routine hearing.

HMO Members **must** select a primary care provider (PCP) and use providers, services, and facilities within the UPMC *for Life* networks.

HMO Members are able to self-direct care to in-network specialists; however, they are encouraged to coordinate care with their PCP.

PPO Members **are not** required to select a PCP, but they are encouraged to do so.

This chapter contains information that 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 **upmchealthplan.com/providers/online/** 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** contact **Provider Services** at **1-866-918-1595 (TTY: 711)** from 8 a.m. to 5 p.m., Monday through Friday.

UPMC for Life HMO

UPMC *for Life* HMO Members **may** select from the following benefit plans:

- UPMC *for Life* HMO Deductible with Rx
- UPMC *for Life* HMO No Rx (*does not offer Medicare Part D prescription drug coverage)*
- UPMC *for Life* HMO Premier Rx
- UPMC *for Life* HMO Rx
- UPMC *for Life* HMO Rx Choice
- UPMC *for Life* HMO Rx Enhanced

Employer groups **may** offer variations of HMO Rx plans, so coverage and Member cost-sharing can vary.

All UPMC *for Life* HMO Members **must** select a PCP in order to receive coverage. If a PCP is not selected, the UPMC *for Life* Health Care Concierge team will assist in that selection. All services, whether coordinated through a PCP or self-directed, **must** be performed by a UPMC *for Life* in-network provider.

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

Most UPMC *for Life* HMO plans offer supplemental coverage for routine chiropractic and routine podiatry visits as well as routine vision, routine hearing, and routine dental care. HMO Members also have additional benefits such as personal counseling through Resources *for Life*, in-home safety assessment, and fitness. Some plans also offer a Flexible Spending card and bathroom safety devices. All HMO Members have access to a visitor travel benefit to receive in-network coverage outside of the service area in select states.

Most UPMC *for Life* HMO Members have copayments for the following:

- Physician office visits
- Emergency department visits
- Prescription drugs

UPMC *for Life* (HMO) offers Members the following preventive services at **no cost** including **no copayment or deductible:**

- Annual wellness visit

  ➢ **Note:** If the Member had Medicare Part B for **longer than 12 months,** they can receive an **annual** wellness visit to develop or update a personalized prevention plan based on their current health and risk factors. The annual wellness visit is covered **once every 12 months.** The Member's annual wellness visit cannot take place **within 12 months** of their *Welcome to Medicare preventive visit*. However, they **do not** need to have had a ***Welcome to Medicare visit*** to be covered for annual wellness visits after they had Medicare Part B for **12 months.**

- Immunizations (administered in the providers office or at a pharmacy)
  - COVID-19 vaccine
  - Flu
  - Hepatitis B (*if the Member is at high **or intermediate risk** of getting hepatitis B)*
  - Pneumonia

  ➢ **Note:** Additional Part D immunizations are covered only when administered at the pharmacy. The vaccines that are covered at pharmacies are listed in the formulary book.

  ➢ **See:** The ***Member's benefit plan*** for specific immunization coverage.

- Screening exams
  - Bone mass measurement
  - Colorectal exams
  - Counseling to reduce alcohol misuse
  - Depression screenings
  - Dilated diabetic retinal eye exams
  - Glaucoma screenings
  - HIV screenings
  - Mammograms
  - Pap and pelvic exams
  - Prostate exams
  - Sexually transmitted infections

- Smoking cessation (Health Education Classes)

A separate copayment **may** apply if additional medical services are rendered during the same visit as a preventive screening exam or a screening service becomes diagnostic in nature.

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

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

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

Key points

Network care:

- PCP is mandatory.
- Network providers and facilities **must** be used.

Emergency services:

- Emergency services by any provider is covered if the Member believes that their health is in serious danger.
- Urgent care by any provider is covered if the Member believes that their condition could rapidly become a medical emergency if left untreated.
- Emergency services, urgent care services, and emergency ambulance transportation incur copayments.
- Copayments for emergency services are waived if the Member is admitted to a facility within **three days** for the same condition.
- Emergency room copays are waived if the Member is admitted as an inpatient or kept as an outpatient in observation. Cost sharing for an inpatient stay, observation stay, or emergency ambulance transportation is **not** waived.

> ➢ **See:** ***Emergency Care for Emergency Department and Emergency Transportation*****,** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

Closer Look at Self-Directed Care

Nonemergency, self-directed care by out-of-network specialists is **not covered** unless prior authorization is obtained through **Utilization Management.**

In-network providers **must** contact Utilization Management by submitting a request for prior authorization through **Provider OnLine** at **upmchealthplan.com/providers.**

Out-of-network providers **must** obtain authorization 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 (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 in- or out-of-network providers. PPO Members incur lower out-of-pocket costs if they use UPMC *for Life* in-network providers and facilities.

UPMC *for Life* PPO Members **may** select from the following plans:

- UPMC *for Life* PPO Essential Care Rx
- UPMC *for Life* PPO Premier Rx
- UPMC *for Life* PPO High Deductible Rx
- UPMC *for Life* PPO Rx Choice
- UPMC *for Life* PPO Rx Enhanced
- UPMC *for Life* PPO Salute (***does not*** *offer Medicare Part D prescription drug coverage)*

Employer groups offer variations of PPO plans, so coverage and Member cost-sharing vary.

UPMC *for Life* (PPO) offers Members the following preventive services at **no cost** including **no copayments or deductibles** when using an in-network provider:

- Annual wellness visits

  ➢ **Note:** If the Member had Medicare Part B for **longer than 12 months**, they can receive an **annual** wellness visit to develop or update a personalized prevention plan based on their current health and risk factors. The annual wellness visit is covered **once every 12 months.** The Member's annual wellness visit cannot take place **within 12 months** of their ***Welcome to Medicare preventive visit.*** However, they **do not** need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after they had Medicare Part B for **12 months.**

- Screening exams
  - Bone mass measurements
  - Colorectal exams
  - Counseling to reduce alcohol misuse
  - Depression screenings
  - Dilated diabetic retinal eye exams

  - Glaucoma screenings
  - HIV screenings
  - Mammograms
  - Pap and pelvic exams
  - Prostate exams
  - Sexually transmitted infections

- Immunizations (administered in the providers office or at a pharmacy)
  - COVID-19 vaccine
  - Flu
  - Hepatitis B (*if the Member is **at high or intermediate risk** of getting hepatitis B)*
  - Pneumonia

➢ **Note:** Additional Part D immunizations are covered only when administered at the pharmacy. The vaccines that are covered at pharmacies are listed in the formulary book.

➢ **See:** The ***Member's benefit plan*** for specific immunization coverage.

- Smoking cessation (Health Education Classes)

A separate copayment **may** apply if additional nonpreventive medical services are rendered during the same visit as the preventive screening exam or if the screening exam becomes diagnostic in nature. Members receiving preventive services out-of-network **may** have a higher cost-share amount.

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

UPMC *for Life* PPO Members **may** have copayments for physician office visits, emergency department visits, or prescription drugs when care is received within the UPMC *for Life* network.

Members **may** have coinsurance, copayments, or deductibles 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 coinsurance or copayment for in- or out-of-network services. The other UPMC *for Life* PPO plan offerings have a deductible only for out-of-network services.

Providers should verify eligibility as well as deductible, copayment, or coinsurance responsibility before a service is performed. Providers **may** verify Member information through **Provider OnLine** at **upmchealthplan.com/providers** or UPMC Health Plan's **IVR system** at **1-866-406-8762.**

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

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

Key points

Network care:

- Members have lower out-of-pocket costs (e.g., copayments or coinsurance) when using in-network providers and facilities.
- Annual deductibles, copayments, maximum limits, and coinsurance **may** apply.

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:

- Emergency services by any provider is covered if the Member believes that their health is in serious danger.
- Urgent care by any provider is covered if the Member believes that their condition could rapidly become a medical emergency if left untreated.
- Emergency services, urgent care services, and emergency ambulance transportation incur copayments.
- Copayments for emergency services are waived if the Member is admitted to a facility within **three days** for the same condition.
- Emergency Room copay is waived if the Member is admitted as an inpatient or kept as an outpatient in observation. Cost sharing for an inpatient stay, observation stay, or emergency ambulance transportation is n**ot** waived.

> ➢ **See:** ***Emergency Services for Emergency Department and Emergency Transportation,*** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

UPMC Health Plan Medicare Supplement

UPMC Health Plan has **two types** of Medicare Supplement plans:

- A **Medicare Supplement plan,** which allows a Member to see any provider for professional and facility services:

- A **Medicare Select plan,** which 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 a service is performed.

> ➢ **Note:** UPMC Health Plan **no longer** sells Medicare Supplement/Select Plans. Even though many of the Supplement/Select Plans were discontinued, Members who were enrolled in these plans were able to keep their Supplement/Select plan. These Members continued to have coverage until they voluntarily terminated it or there was an applicable involuntary termination.

UPMC Health Plan's Medicare Supplement portfolio includes:

- Medicare Supplement plans A, B, C, and F.
- Medicare Select plans A, B, C, and H.

Each plan offers a different combination of benefits for Members.

> ➢ **See:** ***Figure F.1,*** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

Figure: F.1

Covered benefits	Plan A	Plan B	Plan C	Plan F	Plan H
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	•	•	•	•	•
Parts A and 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 are similar, HMO Members **must** use UPMC *for Life* 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 Section*****,** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

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.
- Of the estimated cost for the service for which the Member will be responsible.

The Member **must** agree in writing on an approved form that they will be financially responsible for the service.

> ➢ **Note:** An Advance Beneficiary Notice (ABN) **is not** acceptable for Medicare Advantage Plans. It is only acceptable for Traditional Medicare. 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 those services. For more information about these guidelines or the approval process, contact **Provider Services** at **1-866-918-1595,** Monday through Friday from 8 a.m. to 5 p.m.

> ➢ **See:** ***IDN section for additional information,*** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

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

Ancillary services

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

- Chiropractic care
- Diagnostic services (e.g., lab, or 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
- Nonemergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Respiratory equipment, including oxygen therapy

➢ **Note:** Coinsurance, copayments, or a deductible **may** apply.

Chiropractic care

Manual manipulation of the spine to correct subluxation (the chiropractic coverage offered by traditional Medicare), is available to all UPMC *for Life* Members. Children **younger than age 7** 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 in-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 in-network providers. Copayments apply for care performed by in-network providers. Coinsurance 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, PPO plans give Members coverage for routine chiropractic visits, which is a benefit **not included** in traditional Medicare.

Dental services

HMO and PPO Members have routine dental benefits for cleanings, oral exams, and bitewing x-rays. Copayments and coinsurance **may** apply. Some plans offer a dental allowance for additional services.

Some employer group plans **may** provide **limited** dental coverage. Member benefits can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers** or the **UPMC Health Plan's 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. Deductible and copayments **may** apply to diagnostic services.

Prior-authorization, deductible, copayments, and/or coinsurance **may** apply to high-technology x-ray services (e.g., 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 services

Emergency department services require 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 emergency services.

Closer Look at Emergency Services

The hospital or facility **must** contact **Utilization Management within 48 hours** or on the **next business day** after an emergency admission. Providers **must** contact **Utilization Management** by submitting a request for prior authorization through **Provider OnLine** at **upmchealthplan.com/providers** or by calling **1-800-425-7800.**

Alert—Emergency Services

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

Emergency transportation

Members **do not need** prior authorization for emergency 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
- Wheelchair van transportation

The UPMC *for Life* PPO Salute plan covers a certain number of routine transportation trips to plan approved locations.

➢ **See: upmchealthplan.com/providers/medical resources/manuals/policies-procedures.aspx.**

Hearing services

Diagnostic hearing exams are available to all UPMC *for Life* HMO and PPO Members. Select UPMC *for Life* HMO and PPO plans and some employer group plans also include a diagnostic hearing exam, a routine hearing test, and fitting evaluation for hearing aids. Copayments **may** apply for in-network services. Limitations and discounts 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 **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 **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* in-network hospital, and applicable deductibles and/or coinsurance **may** apply for out-of-network admissions.

Behavioral health and substance use disorder benefits

Behavioral health and substance use disorder benefits and services are managed through UPMC Health Plan Behavioral Health Services (UPMC Health Plan BHS), which provides triage and referral for emergency care **24 hours a day, 7 days a week, 365 days a year.**

Key points

- Inpatient care **may** require a copayment, even if services are performed in an in-network hospital.
- Outpatient behavioral 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 UPMC Health Plan BHS network providers. Behavioral health providers **must** coordinate a UPMC *for Life* Member's care directly with **UPMC Health Plan BHS** at **1-866-441-4185.**

- PCPs **may** contact UPMC Health Plan BHS directly for help finding an in-network provider for a Member.

- Only UPMC Heath Plan BHS **may** authorize behavioral health services.

UPMC Health Plan BHS contact information	
Providers	**1-866-441-4185**
Members	**1-888-251-0083 (TTY: 711)**

➢ **See:** ***UPMC Health Plan Provider Manual:***
- ***Welcome and Key Contacts,*** Chapter A, Table A.4
- ***UPMC Health Plan Behavioral Health Services*****,** Chapter L.

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 in-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 **upmchealthplan.com/providers** or the UPMC Health Plan's **IVR system** at **1-866-406-8762.**

Outpatient surgery
Outpatient surgical procedures performed at an ambulatory surgical center or 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 or pay a copayment and/or coinsurance.

Podiatry 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 or peripheral vascular disease. A copayment **may** apply for care by in-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 by accessing **Provider OnLine** at **upmchealthplan.com/providers** or the UPMC Health Plan's **IVR system** at **1-866-406-8762.**

Closer Look at Orthotics and Prosthetics

An in-network podiatrist **may** supply orthotics or prosthetics to UPMC *for Life* Members only if the podiatrist is also credentialed as a home medical equipment (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 the Member has.

Members with UPMC *for Life* HMO No Rx and UPMC *for Life* PPO Salute only have 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, if a Member's plan has a pharmacy deductible, they are required to pay the full cost of their drug until they reach their plan's deductible amount. Once they have paid the deductible amount or if a Member's plan **does not** have a pharmacy deductible, they are required to pay the copayment or cost-share amounts for medications until their out-of-pocket costs reach a certain dollar amount, the out-of-pocket limit.

After reaching the out-of-pocket limit, Members **no longer** pay a cost-share or copayment.

➢ **See:** ***UPMC for Life Outpatient Prescription Drug Benefit,*** UPMC Health Plan Provider Manual, Chapter J, Pharmacy Services.

Medicare Prescription Payment Plan

Certain Medicare Advantage and Part D plan Members with high drug costs **may** benefit from participating in the Medicare Prescription Payment plan. This program offers UPMC *for Life* Members the option to make monthly payments toward their out-of-pocket prescription drug costs over the course of their plan year instead of paying all at once at the pharmacy. UPMC *for Life* Members with a Medicare Part D plan or Medicare Advantage prescription drug plan can use this payment option for drugs covered by Part D.

All Medicare prescription drug plans offer this payment option and participation is voluntary. This payment option might help Members manage their monthly expenses, but it **does not** save them money or lower their drug costs.

If a Member selects this payment option, each month they will continue to pay their Medicare Advantage or Part D plan premium (if they have one) and will receive a bill from Express Scripts Inc. to pay for their prescription drug cost share (instead of paying the pharmacy at the point of sale). There is **no cost** to participate in the Medicare Prescription Payment Plan, and Members will **not pay** any interest or fees on the amount owed, even if their payment is late.

The pharmacy will be paid in full by UPMC Health Plan at the contracted rate in accordance with the Part D prompt payment requirements. UPMC *for Life* Members will receive information about how to sign up for the Medicare Prescription Payment Program with their welcome kits after their enrollment is confirmed.

The Member **may** opt into the program prior to the beginning of a plan year or in any month during a plan year. They may opt out at any time during the plan year. UPMC *for Life* Members interested in this payment option can enroll online at **express-scripts.com/mppp** or by calling **1-866-845-1803 (TTY: 1-800-716-3231)** for assistance **24 hours a day, 7 days a week.**

Additional details and frequently asked questions about the Medicare Prescription Payment Plan are available at **upmchealthplan.com/medicare/prescription-payment-plan.** Providers that have any questions may contact their **Physician Account Executive** or call **Provider Services** at **1-866-918-1595,** Monday through Friday from 8 a.m. to 5 p.m.

➢ **See:** ***CMS Inflation Reduction Act (IRA) requirements and guidance*** at **cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan** for additional information. Under the IRA, all Medicare prescription drug plans (including both Medicare Advantage Prescription drug and standalone Part D plans) are required to offer the Medicare Prescription Payment Plan.

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, home, or a brief inpatient stay, if 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 **upmchealthplan.com/providers.**

Failure to obtain authorization for this service can result in denied services and **no** payment of claims. A copayment **may** apply. Care in a network SNF has a benefit period of **up to 100 days**, which is calculated just as it is 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,*** UPMC Health Plan Provider Manual, Chapter F, UPMC *for Life* (Medicare).

Benefits for specific Members **may** be verified at **upmchealthplan.com/providers** or by calling UPMC Health Plan's **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 SNF 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.

Routine vision services

Routine vision benefits are provided by UPMC Vision Care which is administered by National Vision Administrators (NVA). HMO and PPO Members have coverage for **one** routine vision exam, **one** contact lens fitting exam and an allowance toward the cost of eyewear.

Eyewear coverage **does not** include lens options, such as tints, progressives, transition lenses, polish,or insurance. The frequency of the services varies by plan type.

The services **may** be received from plan providers (NVA) 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.

UPMC *for Life* providers **may** contact **NVA** directly and Members may contact **UPMC Vision Care.**

Vision contact information	
Provider	**National Vision Administrators** **1-877-262-7870**
Member	**UPMC Vision Care** **1-877-539-3080 (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. Glaucoma screening is also provided under medical benefits and considered a preventive screening, so there is **no** Member cost-sharing when performed by an in-network provider.

UPMC *My*Health 24/7 Nurse Line

This is a **24/7** advice line for Members seeking general health advice or information regarding a specific medical issue. Experienced registered nurses are available **24 hours a day, 7 days a week, 365 days a year** to provide Members with prompt and efficient services. The UPMC *My*Health 24/7 Nurse Line is available for medical questions concerning both adults and children. Members **may** call **1-866-918-1591 (TTY: 711)** any time or log in to**,** the **UPMC Health Plan member site** at **upmchealthplan.com.**

➢ **See:** ***upmchealthplan.com/members/contact/nurse-line.aspx***
for additional information.

UPMC AnywhereCare

UPMC AnywhereCare Virtual Care—UPMC Health plan's telemedicine tool—offers Members access to high-quality care from the comfort of their own home, **24 hours a day, 7 days a week, 365 days a year.**

It works well for issues like rashes, sore throats, colds, and other nonemergency conditions.

Members can have a virtual care visit with a provider right from their smartphone, tablet, or computer. The Member should download the UPMC Health Plan app. They can access it online by visiting **upmchealthplan.com** to register and then selecting UPMC AnywhereCare in the Care section.

Members temporarily traveling outside of Pennsylvania (except Puerto Rico) at the time of service will receive care by an Online Care Network II PC (OCN) provider. OCN is also known as Amwell Medical Gorup. OCN **is not** an affiliate of UPMC Health Plan.

➢ **Alert: Coverage exceptions:**

- AnywhereCare virtual visits are **not covered** for **some** UPMC *for Life* Members using Talk Therapy or Psychiatry services. These services are **only** covered for Medicare Advantage Members
- AnywhereCare providers are **not** available in Puerto Rico.

Services Not Covered

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

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

Services Requiring Prior Authorization

The following services require prior authorization:

- Acupuncture (Medicare-covered for chronic low back pain)
- Inpatient hospital care, except in an emergency
- Inpatient behavioral health care, except in an emergency
- Chemical dependency rehabilitation treatment
- Chemical dependency detoxification treatment
- Nonemergency ambulance services
- Opioid treatment program services
- Outpatient surgery, ambulatory surgery, and observation stays
- Select advanced imaging services
- Select diabetic supplies
- Select diagnostic procedures/tests
- Select durable medical equipment and prosthetic devices
- Select home health care and home infusion services
- Select outpatient rehabilitation services (e.g., PT, OT, or ST)
- Select palliative care services
- Select Part B drugs
- Select Part D drugs (for plans with Part D coverage)
- SNF care, except in an emergency

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

➢ **See:** UPMC Health Plan Provider Manual for additional information:
- ***Provider OnLine,*** Chapter B, Provider Standards and Procedures
- ***How to Contact or Notify Utilization Management,*** Chapter G, Utilization Management and Medical Management.

Integrated Denial Notice

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

If the procedure **is not approved,** both the provider and the Member will receive an integrated denial notice (IDN) from UPMC Health Plan explaining the reason for 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.

> ➢ **Note:** An Advance Beneficiary Notice (ABN) **is not** acceptable for Medicare Advantage Plans, it is only acceptable for Traditional Medicare.

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** 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 or investigative procedures when covered under a Medicare or plan-approved clinical trial; private hospital rooms (if medically necessary); supportive devices for the feet; orthopedic shoes; and cosmetic surgery in cases of accidental injury, breast reconstruction, or another 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 those services. For more information about these guidelines or the approval process, contact **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*****,** UPMC Health Plan Provider Manual, Chapter B, Provider Standards and Procedures.

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

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 (appointed 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),** to discuss the appeal process.

The UPMC *for Life* Health Care Concierge team hours vary.

UPMC *for Life* Health Care Concierge team hours	
Oct. 1, 2024 – Dec. 31, 2024	**8 a.m. to 8 p.m., seven days a week**
Jan. 1, 2025 – March 31, 2025	**8 a.m. to 8 p.m., seven days a week**
April 1, 2025 – Sept. 30, 2025	**Monday through Friday: 8 a.m. to 8 p.m.**

Members who **do not** speak English as their primary language should contact the **Health Care Concierge team** at **1-877-539-3080 (TTY: 711)** to 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 and file an organization determination, coverage determination, appeal, and/or grievance 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 (TTY: 711)** to be connected with a contracted language-translation services representative.

The appointment of representative form is also available in the Medicare section of the UPMC Health Plan website at **upmchealthplan.com.**

A completed appointment of representative statement will:

- Include the name, address, and phone number of the Member.
- Include the Member's Medicare beneficiary identifier (MBI).
- Include the name, address, and phone number of the individual being appointed.
- 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."
- Contain the Member's signature.
  - The Member **must** sign and date the statement.
- Contain the signature of the Member's representative.
  - The Member's authorized representative **must** also sign and date the statement.
- 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/redetermination (appeal) of services or payment that are filed **within 60 calendar days** of the notice of the initial organization determination or coverage determination. Appeals should be sent to:

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 a medical service/item appeal, it will notify the Member and authorize or provide 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* makes a fully favorable decision on a prescription drug appeal, it will notify the Member and authorize or provide the service as expeditiously as the Member's health requires, but **no later than seven calendar days** after receiving the appeal.

If UPMC *for Life* is unable to make a fully favorable decision on a medical service/item, it will forward the case to CMS' 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* is not required to take this action on prescription drug appeals.

UPMC *for Life* will make a decision on appeals regarding payment for medical services/items already received **no later than 60 calendar days** after receiving the appeal. UPMC *for Life* will make a decision on appeals regarding payment for prescription drugs already received **no later than 14 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 an SNF, 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 they **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 provider makes the request or supports the Member who believes that their, health, or ability to regain maximum function is in immediate jeopardy and UPMC *for Life* fails to provide medically necessary covered services. The Member, their health care provider, or an authorized representative should call the **UPMC *for Life* Health Care Concierge team** at **1-877-539-3080 (TTY: 711)** and ask for an expedited appeal. UPMC *for Life* will make its decision **within 72 hours** after receiving the appeal for medical services/items and prescription drugs.

The UPMC *for Life* Health Care Concierge team hours vary:

UPMC *for Life* Health Care Concierge team hours	
Oct. 1, 2024 – Dec. 31, 2024	**8 a.m. to 8 p.m., seven days a week**
Jan. 1, 2025 – March 31, 2025	**8 a.m. to 8 p.m., seven days a week**
April 1, 2025 – Sept. 30, 2025	**Monday through Friday: 8 a.m. to 8 p.m.**

Members who **do not** speak English as their primary language should contact the **Health Care Concierge team** at **1-877-539-3080 (TTY: 711)** to 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—also called a Grievance—about problems that include the following:

- Covered health services, procedures, or items 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 to the UPMC *for Life* Health Care Concierge team in writing or by phone. UPMC *for Life* will inform the Member in writing how the dispute has been resolved **within 30 days** of receipt of the grievance.