

---

# UPMC *for Kids*



- D.2** At a Glance
- D.4** Covered Benefits
- D.10** Benefit Exclusions
- D.12** Member Complaint and Grievance Procedures
- D.17** Member Rights and Responsibilities
- D.19** UPMC *for Kids* Quick Reference Guide

## 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 to provide 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, and dental and vision services. In addition to these benefits, UPMC *for Kids* offers enhanced services and care options that are not CHIP benefits. The enhanced benefits include orthodontia, (when medically necessary), smoking cessation counseling, nutrition counseling, the *MyHealth Advice Line*, *MyHealth Online*, the *MyHealth* health promotion programs, and the *Healthy Living Rewards for Kids* program.

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; however, they are encouraged to coordinate care with their PCP.

Based on a family's income, children can be enrolled in *free* CHIP, *low cost* CHIP or *at 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 member's identification card includes information on copayments for PCP visits, specialist and behavioral health visits, emergency room visits, and pharmacy services. Some services have benefit maximums that are based on the UPMC *for Kids* benefit year, which runs August 1 to July 31.

This chapter contains information providers need to know to deliver care to members enrolled in UPMC *for Kids*. The type of CHIP coverage a family has may change, based on the family's income, and this may impact copayments. Providers should go to [www.upmchealthplan.com](http://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, Monday through Friday, from 8 a.m. to 5 p.m.



### Key Points

- 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 (ages birth up to 19) are covered.
- Most preventive services are fully covered.
- Obstetricians-gynecologists are credentialed for routine gynecological visits and mammogram screenings, even when not credentialed as PCPs.
- Emergent or urgent care by any provider is covered if the member believes he or she has a life-threatening situation.
- Benefit limitations apply for the following services:
  - Inpatient benefits for medical services, mental health services, skilled nursing, and rehabilitation
    - Inpatient substance abuse detoxification
    - Substance abuse inpatient rehabilitation and non-hospital residential care
    - Outpatient mental health
    - Outpatient substance abuse rehabilitation
    - Outpatient occupational, physical, and speech therapy
    - Home health
    - Hearing exams and aids
    - Durable medical equipment
    - Smoking cessation counseling
- Dental Care
- Vision Care

# Covered Benefits

## At a Glance

UPMC for Kids network PCPs, specialists, therapists, nursing homes, hospices, 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](http://www.upmchealthplan.com).

## Ambulance

Ambulance service is covered when using a specially equipped vehicle 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.

Non-emergency 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/location, a hospital outpatient department, or a member's home.

Ancillary service benefits include, but are not limited to:

- Ambulance
- Diabetic supplies (including glucometers, test strips, lancets, insulin, and syringes); copayments apply for some members under the pharmacy benefit
- Diagnostic services (e.g., ECG, EEG)
- Durable medical equipment – limited to \$5,000 per plan year
- Home health care (See In-Home Services below)
- Hospice care
- Laboratory services
- Orthotics and prosthetics

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, please go to [www.upmchealthplan.com](http://www.upmchealthplan.com).

Ancillary services or equipment may be subject to benefit limitations or require prior authorization. Please refer to the *UPMC for Kids* Quick Reference Guide for prior authorization requirements.

▶ See Quick Reference Guide, chapter D.

## In-Home Services

In-home services are limited to 60 days per plan year and include:

- Skilled/intermittent nursing
- Private duty nursing (limited to a maximum of 16 hours per day)
- Physical, speech, and occupational therapy
- Home infusion therapy
- Hospice care



## Closer Look at Specialized Equipment

If a member requires specialized equipment or modifications, the ancillary provider should contact Medical Management at 1-800-425-7800. Medical Management will be able to verify the amount of the DME benefit used, determine whether the equipment is covered and whether prior authorization is required. Please refer to the Quick Reference Guide to determine which equipment requires prior authorization.

---

## Admissions

Admissions to network hospitals must be approved by *UPMC for Kids* prior to a member's admission.

Admissions to a non-participating hospital must be authorized prior to admission and may be considered if the service cannot be performed at a participating hospital.

▶ See Quick Reference Guide, chapter D.

Hospitals are required to notify Medical Management of inpatient admissions at 1-800-425-7800 by the next business day.

The inpatient benefits are described below:

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

All of these types of admissions are subject to a combined maximum limit of 90 days per plan year. Some of the inpatient mental health days may be exchanged for intensive outpatient or partial hospitalization visits.

## Inpatient Substance Abuse

In addition to the Hospital Admission benefits described above, the member has inpatient substance abuse benefits. These include:

- Inpatient substance abuse detoxification – limited to 7 days maximum per admission with no lifetime maximum.
- Substance abuse inpatient rehabilitation and non-hospital residential services – limited to 90 days maximum per plan year with a lifetime maximum of 360 days.

Mental health and substance abuse benefits are managed through UPMC Health Plan Behavioral Health Services. Providers can access UPMC Health Plan Behavioral Health Services by calling **1-888-251-2224**. Members can call 1-800-650-8762 for information regarding participating mental health and substance abuse providers and benefits.

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

## Dental Benefits

### Dental Care

Doral Dental Services of Pennsylvania administers routine and emergency dental benefits for UPMC *for Kids* members. Routine and restorative dental care is a covered benefit when performed by a participating dentist. Diagnostic and preventive services such as oral exams, cleanings, and x-rays are covered benefits and do not require prior authorization.

Providers may call Doral directly at 1-800-341-8478. Members may call Doral through UPMC *for Kids* Member Services at 1-800-650-8762.

### Orthodontia

Orthodontia, when medically necessary, is an enhanced benefit offered by UPMC *for Kids*. Orthodontia services require prior authorization. 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 Doral Dental provider. If oral surgery is performed under the medical benefit, some members have copayments.



## Alert

UPMC *for Kids* medical benefit; however, this benefit must be used within 72 hours of the particular injury to be covered under the medical benefit.

---

## 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 [Quick Reference Guide, chapter D](#).

Please review specific benefit designs at [www.upmchealthplan.com](http://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 following are covered:

Primary care provider visits, including:

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

Specialist visits, including:

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

Obstetrician-gynecologist services, including:

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

Allergy services including diagnostic testing, allergy serum, and allergy injections  
Hearing exams and aids – limited to every 2 years.

## Emergency Services

Coverage for emergency room visits is provided for the sudden onset of a medical condition with symptoms that are of such severity, or pain that is severe enough, that someone who has an average knowledge of health and medicine could reasonable 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 ID card. The copayment is waived if a member is admitted. 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

The hospital or facility should notify Medical Management at 1-800-425-7800 within 24 hours or on the next business day following the emergency admission.

---

## Outpatient Mental Health and Substance Abuse Benefits

Based on the specific CHIP program in which the member is enrolled, the member may have copayments. The benefits are:

Outpatient mental health:

- Limited to 50 visits per plan year

Outpatient substance abuse rehabilitation services:

- Limited to 90 full sessions or equivalent partial visits per plan year. (These may be exchanged to allow other levels of treatment.)

Mental health and substance abuse benefits are managed through UPMC Health Plan Behavioral Health Services. Providers can access UPMC Health Plan Behavioral Health Services by calling 1-888-251-2224. Members may call 1-800-650-8762 for information regarding participating mental health and substance abuse providers and benefits.

Behavioral health providers must coordinate a member's care directly by calling the number listed on the member's identification card. Annual maximums apply for treatment of substance abuse and general mental illness.



### Alert

Members may self-direct care to a behavioral health provider. Behavioral health providers are encouraged to communicate with other treating providers about the member's care, as applicable. Members do not have to obtain a referral from their PCP.

---

## Outpatient Surgery

Outpatient surgery is covered when provided at a participating UPMC *for Kids* facility and deemed medically necessary and the PCP (when applicable), ob-gyn, or network specialist coordinates it. Some procedures may require prior authorization.

▶ See [Quick Reference Guide, chapter D](#).

## Outpatient Services

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

Diabetic education

Maternity education and services, including:

- Breast feeding classes
- Breast pumps
- Childbirth education for Lamaze I and Lamaze refresher classes
- Parenting education

Medical therapy services, including:

- Chemotherapy
- Dialysis
- Infusion therapy
- Radiation therapy
- Respiratory therapy

Nutritional counseling for any diagnosis, Occupational, physical, and speech therapy – limited to 60 visits per therapy type per plan year – Pain management Tobacco cessation counseling (up to 50 visits per plan year)

## Prescription Drug Coverage

UPMC *for Kids* provides coverage for prescription drugs and some over-the-counter drugs with a physician's prescription. Some members have copayments for covered drugs. To view the UPMC *for Kids* drug benefit, please see the *Pharmacy Services* chapter, *UPMC for Kids Pharmacy Program*, chapter J.

## Routine Vision Benefits

Routine vision benefits are provided by OptiCare Managed Vision. Members must use a participating vision provider. Members may self-direct care. Vision benefits include:

- 1 routine eye exam per plan year
- Allowance of \$100 for prescription lenses and frames and contact lenses per plan year

Providers and Members may call OptiCare directly at 1-866-921-7965.



### Closer Look at Vision Benefits for a Medical Condition

UPMC *for Kids* covers prescription lenses and frames, and the fitting and adjustment of contact lenses in full for a diagnosis of cataracts, keratoconus, or aphakia. Members may have a co-payment for vision services provided under the medical benefit.

---

## Women's Care

Benefits for preventive women's care include an annual Pap test, annual gynecological exam, and clinical breast examination. 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.

# 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](http://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
- Bridges, unless required as a result of an accident or injury
- 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; lost, stolen or destroyed medications
- Charges for completing forms or missed appointments
- Chiropractic care and related services
- Court-ordered services when not medically necessary or appropriate
- Custodial care
- Dentures, unless required when surgery for trauma or disease results in a need for dentures
- Experimental and investigational procedures, treatment, equipment, drugs, and devices, including organ transplants
- Home care services for chronic conditions requiring long periods of care or observation, dietary services, homemaker services, or custodial care
- Long-term care
- Medically unnecessary services
- Mental retardation services
- Motor vehicle accident and workers' compensation related services when payable under these conditions
- Non-emergency transportation
- Non-medical items
- Non-prescription glasses or contact lenses
- Nutritional supplements
- Pregnancy termination services, except for those that are a result of rape or incest, or if the life of the mother is endangered
- Services provided without the required prior authorization
- Services by non-participating providers unless prior authorization was obtained from UPMC for Kids
- Services to treat Temporomandibular Joint Syndrome (TMJ) with the exception of surgery for Temporomandibular Joint Disease.
- Sterilization procedures
- Third-party physical evaluations and examinations primarily to meet a requirement of schools, sports, camps, or driver's license
- Weight reduction programs or surgery

# Member Complaint and Grievance Procedures

## What Is a Complaint?

A complaint is when a member is dissatisfied with the services they receive from UPMC *for Kids* or their provider, payment of services, or benefit structure. Members must file a complaint within 180 days from the date of the event

## What Should Members Do if They Have a Complaint?

Members should call Member Services at 1-800-650-8762 or write to:

UPMC *for Kids*  
Complaint and Grievance Department  
P.O. Box 2939  
Pittsburgh, PA 15230-2939

TTY users should call 1-800-361-2629. Non-English-speaking members should call Member Services at 1-800-650-8762 to be connected with our contracted language translation services representatives.

UPMC *for Kids* will investigate and review the complaint within 30 calendar days and send the member a letter within 5 business days explaining the decision.

## What if Members Are Still Unhappy with the Decision?

Members unhappy with the First-Level decision may make a Second-Level Complaint with UPMC *for Kids*. That complaint must be received within 60 calendar days from the date the member receives written notice on the First-Level Complaint decision. Members and/or an appointed representative will have 15 days advance notice of the date and time of the review meeting. Members have the right to meet with the Second-Level Committee in person or by telephone and voice their opinions. The Second-Level Review is conducted within 30 calendar days from the receipt of the request for a Second-Level Complaint. Members will be notified by mail within 5 business days after the Second-Level Complaint Committee reaches a decision.

## What Can Members Do if They Do Not Like the Decision of the Second-Level Committee?

Members 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 Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve policies and procedures.

Complaints must be sent in writing to either:

PA Department of Health  
Bureau of Managed Care  
Health & Welfare Building, Room 9  
12<sup>th</sup> and Forster Streets  
Harrisburg, PA 17120  
888-466-2787  
TTY: 800-654-5984

or

Pennsylvania Insurance Department  
Bureau of Consumer Services  
1209 Strawberry Square  
Harrisburg State Office Building #1  
Harrisburg, PA 17120  
877-881-6388

## What Is a Grievance?

A grievance is filed when members are unhappy about UPMC *for Kids*' decision to:

- Fully or partially deny payment
- 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 Do Members Initiate a First-Level Grievance?

When UPMC *for Kids* issues a denial, decreases a service, or approves a service different from the service requested, members will receive a letter informing them about the grievance process. The grievance process has two steps: First-Level Grievance and Second-Level Grievance. Members have the right to participate in the Second-Level Grievance review.

Members must file a grievance within 180 days upon receipt of the notice from UPMC for Kids. Members may send a grievance letter or call Member Services at 1-800-650-8762. TTY users should call 1-800-361-2629. Non-English-speaking members should call Member Services at 1-800-286-4242 to be connected with our contracted language translation services representatives.

Providers may, with the member's written consent, file a grievance on a member's behalf. Providers may request the member's written consent at the time of a treatment or service; however, the provider cannot make the 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.

The grievance should be sent to:

UPMC for Kids  
Complaint and Grievance Department  
P.O. Box 2939  
Pittsburgh, PA 15230-2939

---



#### Alert

The member and his or her provider may not each file a separate grievance for the same denied treatment or service.

---

UPMC for Kids will review the First-Level Grievance within 30 calendar days and send the member a letter with the decision within 5 business days. This letter will inform the member of the reason for the decision and how to file a Second-Level Grievance within 60 calendar days of receipt of the notice of the First-Level decision.

### Second-Level Grievance

UPMC for Kids will conduct a hearing within 30 calendar days of the receipt of the request for a Second-Level Grievance. One of the members of the Second-Level Committee will either be a Dentist or Licensed Physician. The member and the member's provider may participate in the Second-Level Grievance Committee meeting in person or by telephone. Members and/or an appointed representative will have 15 days advance notice of the date and time of the meeting.

UPMC for Kids will inform the member of its decision by mail within 5 business days after the Second-Level Grievance review is completed.

## External Grievance Procedure

After members exhaust the Internal Grievance Process, they may request an External Grievance through the Pennsylvania Department of Health by calling or sending a letter to the UPMC *for Kids* Complaints and Grievances Department.

Members must ask for an External Grievance within 15 calendar days of receiving a letter from UPMC *for Kids* about a Second-Level Grievance denial.

UPMC *for Kids* will notify the member of the External Grievance Review entity's name, address, and phone number so that the member, if desired, can send the reviewer any additional information the member feels would help his or her case.

The External Grievance reviewer will notify the member in writing of the decision within 60 calendar days of filing the External Grievance.

## Expedited Complaints and Grievances

If a provider believes the usual timeframes for deciding a member's complaint or grievance will harm his or her health, the member can write to or call Member Services at 1-800-650-8762 and request that the complaint or grievance be expedited.

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



### Alert

For an expedited complaint or grievance, the provider must indicate in writing that a member's life or health is at risk. UPMC *for Kids* will send a letter within 48 hours informing the member of its decision.

---

## Expedited External Review

Upon receipt of the Expedited Internal Review decision, a member has 2 business days to contact UPMC *for Kids* and request an Expedited External Review. Similar to the External Grievance process outlined above, a certified Utilization Review Entity (CRE) will conduct the External Review within 2 business days and notify the member of the decision.

A copy of the full UPMC *for Kids* Member Complaint and Grievance process can be viewed online at [www.upmchealthplan.com](http://www.upmchealthplan.com).

## Member Rights and Responsibilities

The list of specific rights and responsibilities the 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 your child's rights and responsibilities
- To be treated with respect and recognition of your child's dignity and right to privacy
- To participate with practitioners in decision-making regarding your child's health care
- To receive clear and complete information from your child's doctor about your child's health condition and treatment
- To participate in a candid discussion of appropriate or medically necessary treatment options for your child's condition, regardless of cost or benefit coverage
- To voice complaints, grievances, or appeals about the Health Plan, the care provided, or your child's practitioner or provider
- To choose your child's practitioner or provider from the list of network providers and to receive timely care in an emergency
- To see your child's medical records, to keep copies for yourself, and to ask to have corrections made, if needed
- To have your child's medical information kept confidential whether it is in written, oral, or electronic format
- To make decisions about your child's treatment, including the right not to participate in research, and to refuse treatment, as long as you understand that by refusing you may cause your child's health problem to get worse or possibly become fatal
- To make recommendations regarding the 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 yourself, and for purposes other than treatment, payment, and operation (TPO)

### Responsibilities

- To provide, to the extent possible, information that UPMC Health Plan and its practitioners and providers need in order to care for your child
- To follow plans and instructions for care that you have agreed on with your child's practitioners
- To treat your child's doctor and other health care workers with dignity and respect, which includes being on time for appointments and calling ahead if you need to cancel an appointment
- To tell your child's practitioner as much about your child's medical history as you know
- To follow the your child's doctor's directions, such as having your child take the right amount of medication at the right times if you 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 your child may have and developing mutually agreed upon treatment goals
- To provide a safe environment for services rendered in your place of residence
- To pay any applicable fees

# *Quick Reference Guide*

The quick reference guides are available in the Reference Library on Provider OnLine at [www.upmchealthplan.com](http://www.upmchealthplan.com).

Hard copies are available upon request. Please contact Provider Services at the numbers listed below:

- UPMC *for Kids* – 1-800-650-8762