
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 dental care, hearing services, and vision care.

HMO and Specialty Plan members must select a primary care provider, or PCP, and they must use providers, services, and facilities within the UPMC *for Life* and UPMC *for Life* Specialty Plan 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. 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, PPO and Specialty Plan members enrolled in UPMC *for Life*. Because HMO and PPO member benefits change annually and Specialty Plan member benefits may change even more frequently, 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 **1-877-539-3080**, or UPMC *for Life* Specialty Plan **Provider Services** at **1-800-606-8648**, Monday through Friday, from 8 a.m. to 5 p.m., and on Saturday from 8 a.m. to noon.

UPMC for Life HMO

UPMC *for Life* HMO members may select between two benefit levels: UPMC *for Life* HMO,

which does not offer Medicare Part D prescription drug coverage, and UPMC *for Life* HMO Rx, which offers Medicare Part D prescription drug coverage. Employer groups may offer variations of these two plans, so coverage may 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. Copayments are listed on the member's identification card. Most preventive services, such as annual routine physicals, are fully covered, although copayments may apply.

▶ See *Benefits and Services for HMO and PPO Members*, 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, or by calling the Health Plan's Interactive Voice Response (IVR) system at 1-866-406-8762.

▶ See *Member Administration Identifying Members and Verifying Eligibility*, chapter I.

Key Points

- PCP is mandatory.
- Network providers and facilities must be used.
- Routine preventive care is covered only if provided by PCPs (or specialists who are credentialed as PCPs).
- Routine physicals, immunizations (please refer to the member's benefit plan for immunization coverage), and annual screening exams are covered, although copayments may apply to physical exams.
- 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 if untreated, his or her condition could rapidly become a medical emergency. Emergency services, urgently needed care, and emergency ambulance transportation may incur copayments, which are waived if the member is admitted to a facility within 3 days for the same condition.



Closer Look at Self-Directed Care

Non-emergent, self-directed care by out-of-network specialists is not covered unless prior authorization is obtained through **Medical Management** at **1-800-425-7800** Monday through Friday, from 8 a.m. to 4:30 p.m.

UPMC for Life PPO

UPMC *for Life* PPO members do not select a primary care provider, or PCP, in order to receive coverage. 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, which does not offer Medicare Part D prescription drug coverage, and UPMC *for Life* PPO Rx, which offers Medicare Part D prescription drug coverage. Employer groups also may offer variations of these two plans, so coverage may vary.

Most preventive services are fully covered, including an annual routine physical, although cost-share may apply. Most UPMC *for Life* PPO members 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 and coinsurance when care is received outside the UPMC *for Life* network.

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

- ▶ See *Member Administration* chapter, *Identifying Members and Verifying Eligibility*, chapter I.

Key Points

Network Care:

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

- Routine physicals, immunizations, and annual screening exams are covered, although copayments may apply to the physical exams.
- Most preventive services, including routine physical exams for adults and children, are fully covered. A copayment 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 and coinsurance limits apply.
- Members may be responsible for the difference between the provider's charges and the 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 if untreated, his or her condition could rapidly become a medical emergency. Emergency services, urgently needed care, and emergency ambulance transportation incur copayments, which are waived if the member is admitted to a facility within 3 days for the same condition.

UPMC for Life Specialty Plan

UPMC for Life Specialty Plan is a Medicare Advantage plan that offers prescription drug coverage in addition to those medications offered by traditional Medicare.

All UPMC for Life Specialty Plan members must select a primary care provider, or PCP, in order to receive coverage. If a PCP is not selected, a UPMC for Life Specialty Plan 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 Specialty Plan provider.

This plan allows members to see participating specialists without a referral from their PCP. Women may self-direct care to ob-gyns for routine annual exams.

Most UPMC for Life Specialty Plan members do not have copayments for physician office visits; however, they may incur copayments for preventive care services, emergency room visits and pharmaceuticals. Copayments are listed on the member's identification card. Most preventive services, such as annual routine physicals, are fully covered.

▶ [See *Benefits and Services for HMO, PPO and Specialty Plan Members*, chapter F.](#)

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

▶ See *Member Administration Identifying Members and Verifying Eligibility*, chapter 1.

Key Points

- PCP is mandatory.
- Network providers and facilities must be used.
- Routine preventive care is covered only if provided by PCPs (or specialists who are credentialed as PCPs).
- Routine physicals, immunizations (please refer to the member's benefit plan for 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, if untreated, his or her condition could rapidly become a medical emergency.



Closer Look at Self-Directed Care

Non-emergent, self-directed care by out-of-network specialists is not covered unless prior authorization is obtained through **Medical Management** at **1-800-425-7800** Monday through Friday, from 8 a.m. to 4:30 p.m.

UPMC Health Plan Medicare Select

Medicare Select is a Medicare supplement plan. While members may see any provider, they must use the UPMC *for Life* facility network in order to have services and treatments covered at the highest level.

Traditional Medicare is the primary payor, and all claims must be submitted to Medicare first. As a "supplement," Medicare Select will receive the claim after traditional Medicare has paid its portion. Providers should verify eligibility and copayment responsibility before the service is performed.

UPMC Health Plan's 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.

Plan	Benefits
A	<ul style="list-style-type: none"> • Basic benefits *
B	<ul style="list-style-type: none"> • Basic benefits * • Part A deductible
C	<ul style="list-style-type: none"> • Basic benefits * • Part A deductible • Part B deductible • Skilled nursing coinsurance • Foreign travel emergency (after \$250 deductible, 20% for members up to \$50,000 lifetime maximum)
H	<ul style="list-style-type: none"> • Basic benefits * • Part A deductible • Skilled nursing coinsurance • Foreign travel emergency (after \$250 deductible, 20% for members up to \$50,000 lifetime maximum)

* Basic benefits include Part A coinsurance and 365 additional days after Medicare benefits end, Part B coinsurance, and first 3 pints of blood/year.

Benefits and Services for HMO, PPO, and Specialty Plan 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. PPO members may use out-of-network providers and facilities at higher out-of-pocket costs. Specialty Plan members may use providers that participate in the UPMC *for Life* Specialty Plan network.

Some benefits and services require authorization.

- ▶ See [UPMC for Life Quick Reference Guide](#) or [UPMC for Life Specialty Plan Quick Reference Guide](#), chapter F.

A provider may bill a UPMC *for Life* member for a non-covered service or item only if, before performing the service, the provider informs 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.

The member must agree in writing on an approved Medicare form (sometimes called an advance beneficiary notice) that he or she will be financially responsible for the service.

Providers should refer to **www.upmchealthplan.com** for detailed information about a member's specific benefits and possible service limitations.

Ancillary Services

Medical Management at **1-800-425-7800** can assist providers with the coordination of complex ancillary services such as:

- 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

Copayments 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. Copayments apply, and some members have visit limitations. 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. 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. Coinsurance and deductibles apply for care performed by out-of-network providers. Member costs may be higher for out-of-network care.

For Specialty Plan members: These services do not have to be coordinated by a member's PCP but must be performed by network providers. Coinsurance applies for Medicare-covered benefits, and routine care is not covered.

Dental Services

Dental benefits are provided by Doral Dental Services of Pennsylvania.

Doral provides routine dental services, including oral exams and cleanings. Copayments and benefit limitations may apply. PPO members may use out-of-network providers; however, some PPO members may have to satisfy a deductible, an annual maximum limit, and/or coinsurance.

For UPMC *for Life* Specialty Plan members: Coverage is provided for routine oral exams, cleanings, and X-rays every six months along with fillings and simple extractions.

Comprehensive coverage is provided up to an annual limit of \$250. Providers may call **Doral** directly at **1-800-341-8478**. Members may call **Doral** directly at **1-800-787-3157**.

Diagnostic Services

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

Copayments may apply to high-technology x-ray services (CT, MRA/MRI, PET scan, nuclear medicine).

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 Department Care

Emergency department care typically requires a copayment, which is waived if the member is admitted to the hospital within 3 days for the same condition.

If a member arrives at the emergency department by ambulance, the copayments for the emergency department as well as the ambulance are waived if the member is admitted within 3 days for the same condition. HMO members should notify their PCPs within 24 hours or as soon as reasonably possible after receiving the emergency service. For UPMC *for Life* Specialty

Plan members: There is no waiver of the emergency department copayment even if the member is admitted to the hospital within three days for the same condition. Members should notify their PCPs within 24 hours or as soon as reasonably possible after receiving the emergency service.



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.



Closer Look at Emergency Care

The hospital or facility must contact **Medical Management** at **1-800-425-7800** within 48 hours or on the next business day after the emergency admission.

Hearing Services

Hearing exams are available to all UPMC *for Life* HMO, PPO, and Specialty Plan members. Coverage includes 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.

UPMC *for Life* Specialty Plan coverage includes an annual diagnostic hearing exam and routine hearing test. Fittings and evaluation for a hearing aid are covered every three years. Coinsurance may apply. Hearing aids are covered up to \$1,000 every three years.

PPO members may use out-of-network providers. Some PPO members may have to satisfy a deductible, copayments, an annual maximum limit, and/or coinsurance.

Inpatient Hospital Care

Inpatient hospital care requires authorization before admission, except in an emergency. Providers should call **Medical Management** at **1-800-425-7800** for authorization. Failure to do so can result in significantly higher member costs. Providers also must call Medical Management to authorize admissions within 48 hours or on the next business day.

- ▶ [See UPMC for Life Quick Reference Guide or UPMC for Life Specialty Plan Quick Reference Guide, chapter F.](#)

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

HMO members have copayments for each hospital admission.

Some PPO members have copayments for each admission to a UPMC for Life network hospital and limitations on out-of-network care in addition to applicable deductibles, annual maximum limits, and/or coinsurance.

Mental Health and Substance Abuse Benefits

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

Providers may phone **BHS** at **1-888-251-2224**.

Members may phone **BHS** at **1-888-251-0083**.



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 abuse services may require a copayment for individual therapy or group therapy.
- Members may self-refer their behavioral health services to BHS. Behavioral health providers must coordinate a UPMC for Life member's care directly with **BHS** at **1-888-251-2224**.
- PCPs may contact BHS directly for help finding a network provider for a member.
- Only BHS may authorize behavioral health services.
- PPO members using out-of-network facilities have an annual outpatient limit, annual deductibles, copayments, and/or coinsurance.

Office Visits

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

UPMC for Life may cover an enhanced physical examination for UPMC for Life members who became eligible for Medicare after Jan. 1, 2005. Providers should verify the member's eligibility for this benefit at **www.upmchealthplan.com**.

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. There are no therapy limits for services performed by network providers.

PPO members may have to satisfy a deductible and/or coinsurance. Providers should verify the member's eligibility for this benefit at www.upmchealthplan.com, or by calling the 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 also may have to satisfy a deductible 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; however, some PPO members may have to satisfy a deductible and/or coinsurance.

Individual podiatric benefits may be verified at www.upmchealthplan.com, or by calling the 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 also is 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 the 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 or UPMC *for Life* PPO have only an enhanced Medicare Part A and B plan with the Health Plan. In addition to the member's medical coverage, a limited number of drugs mandated by the Centers for Medicare and 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 \$2,700. Members are then required to pay the full amount for medications until they reach \$4,350 in out-of-pocket costs. After reaching \$4,350, members generally pay a \$2.40 copayment for generic and preferred brand drugs that are multi-source and \$6.00 for all other drugs, or a 5% coinsurance, whichever is greater. These dollar values are based on 2009 values which are adjusted annually by CMS.

Members who have UPMC *for Life* HMO Rx or UPMC *for Life* PPO Rx plan have coverage for formulary outpatient prescription drugs as described in the paragraph above and enhanced Part A and B Medicare coverage, including Part B medications.

UPMC *for Life* Specialty Plan members have \$0.00 copayment on generic drugs including brand-name drugs treated as generic. Copayments apply for all other drugs and are based on the member's income level.

To view the UPMC *for Life* outpatient prescription drug benefit please see the *Pharmacy Services UPMC for Life Pharmacy Program*, chapter J.

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



Closer Look at Injectable Medications

Injectable medications, when administered by a provider during an office visit, may be covered under the medical plan when billed with the office visit, even if the UPMC *for Life* member does not have a prescription drug 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, from home, or from a brief inpatient stay, as long as the care is medically appropriate.

Providers must call **Medical Management** at **1-800-425-7800** Monday through Friday, from 8 a.m. to 4:30 p.m., to obtain prior authorization for skilled nursing facility admissions. Failure to obtain authorization for this service can result in significantly higher costs.

There is no copayment for the first 20 days; a copayment may apply for subsequent days. 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; however, some PPO members may have to satisfy a deductible and/or pay coinsurance.

▶ See *Closer Look at Benefit Periods*, chapter F.

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

▶ See *UPMC for Life or UPMC for Life Specialty Plan Quick Reference Guide*, chapter F.



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 3 days with the same condition.

Routine Vision Services

Routine Vision benefits are provided by OptiCare Managed Vision. OptiCare provides routine vision services, including exams and eyewear (glasses or contacts).

Copayments and benefit limitations may apply. PPO members may use out-of-network providers; however, some PPO members may have to satisfy a deductible, an annual maximum limit, and/or coinsurance.

UPMC *for Life* Specialty Plan members: Routine eye exams are covered once every two years. Eyewear (one pair of glasses or contacts) is covered every two years up to a limit of \$350.00. Specialty Plan members are eligible to receive Medicare-covered eye exams and eyewear; however, coinsurance may apply.

For UPMC *for Life*, Providers and Members may call **OptiCare** directly at **1-866-921-7963**.

For UPMC *for Life* Specialty Plan, Providers and Members may call **OptiCare** directly at **1-866-921-7964**.



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.

Services Not Covered

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

- Alternative medicine
- Conditions covered through other programs (e.g., military service, workers' compensation, motor vehicle insurance)
- Experimental/investigative treatments
- Most over-the-counter treatments
- Non-medically necessary treatment (e.g., cosmetic surgery)
- Optional programs, unless provided through a health management program (e.g., smoking cessation, weight control)
- Private duty nursing

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 file the appeal for them.

HMO and PPO members should contact **Member Services** at **1-877-539-3080** Monday through Friday, from 8 a.m. to 5:30 p.m., and on Saturday from 8 a.m. to noon, to discuss the appeal process. **TTY** users should call **1-800-361-2629**. Non-English-speaking members should contact Members Services at **1-877-539-3080**, where they will be connected with our contracted language-translation services representatives.

Specialty Plan members should contact **Member Services** at **1-800-606-8648** at the times stated above. **TTY** users should call **1-866-405-8762**.

Appointing an Authorized Representative

Members may appoint a family member, friend, physician, or attorney to act as their authorized representative by following the steps below. Members may obtain forms by calling UPMC *for Life* **Member Services** at **1-877-539-3080**. **TTY** users should call **1-800-361-2629**. Non-English-speaking members should contact Members Services at **1-877-539-3080**. The form is also available on the Health Plan website at **www.upmchealthplan.com** in the Medicare section.

1. Furnish the member's name, Medicare number, and 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."

2. Obtain signature of the member.

The member must sign and date the statement.

3. Obtain signature of the member's representative.

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

4. Include the signed statement with the appeal.

The member must include the signed statement with the appeal.

Filing an Appeal

UPMC *for Life* accepts written requests for standard reconsideration (appeal) of services or payment that are filed by mail or faxed 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

UPMC *for Life* Specialty Plan

Appeals/Grievances

PO Box 2939

Pittsburgh, PA 15230-2939

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.

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.

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 certification that the enrollee needs an expedited appeal and explain the medical necessity for such. Based on the expedited timeframes, 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 **Member Services** at **1-877-539-3080** Monday through Friday, from 8 a.m. to 5:30 p.m., and on Saturday from 8 a.m. to noon, and ask for an expedited appeal. **TTY** users should call **1-800-361-2629**. Non-English-speaking members should contact Member Services at **1-877-539-3080**.

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.

Quick Reference Guide

The quick reference guides are available in the Reference Library on Provider OnLine at www.upmchealthplan.com.

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

- UPMC *for Life* — **1-877-539-3080**
- UPMC *for Life* Specialty Plan — **1-800-606-8648**