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# Member Administration



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# Member Identification Cards

The card shown below is a sample of an identification (ID) card for a typical commercial HMO or POS member or a UPMC *for Life* HMO member.

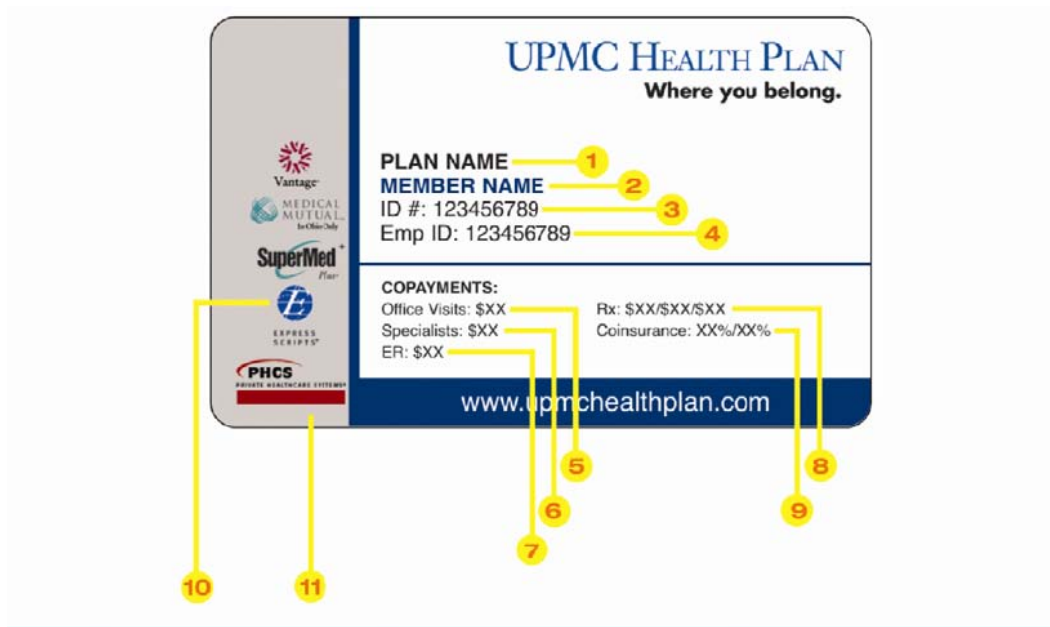
Table I: Typical HMO/POS Member ID Card

1	Plan name	7	Copayment for office visits to member's primary provider	10	Prescription drug copayments
2	Member name	8	Copayment for office visits other than to member's primary provider	11	Coinsurance for services provided by network providers/coinsurance for out-of-network providers
3	Member identification number	9	Copayment for non-admitted treatment in a hospital emergency department	12	Express Scripts logo indicates the member has prescription drug coverage
4	Employer identification or group number			13	Logos indicate the member's coverage with other vendors
5	Primary care provider				
6	Primary care provider's telephone number				

NOTE: If a member has a deductible, the information will be listed below the coinsurance information.

The card shown below is a sample of an identification (ID) card for a typical commercial EPO and/or PPO member.

Table II: Typical EPO/PPO Member ID Card



- |   |   |   |
|---|---|---|
| 1 Plan name                               | 5 Copayment for office visits to member's primary provider                | 8 Prescription drug copayments  |
| 2 Member name                             | 6 Copayment for office visits other than to member's primary provider     | 9 Coinsurance for services provided by network providers/coinsurance for out-of-network providers |
| 3 Member identification number            | 7 Copayment for non-admitted treatment in a hospital emergency department | 10 Express Scripts logo indicates the member has prescription drug coverage                       |
| 4 Employer identification or group number |   | 11 Logos indicate the member's coverage with other vendors  |

NOTE: If a member has a deductible, the information will be listed below the coinsurance information.

# Member Rights and Responsibilities

The Health Plan recognizes that health care providers have rights and responsibilities related to their work with members, other health care providers, and the Health Plan. The Health Plan's commitment to providers is expressed in the provider rights and responsibilities statement.

- ▶ *See Provider Standards and Procedures chapter, Provider Rights, Responsibilities, and Roles, chapter B.*

Periodic revisions to this document are communicated via the Accountable Provider newsletter. These rights and responsibilities also can be found on the Health Plan website at [www.upmchealthplan.com](http://www.upmchealthplan.com). Paper copies of the document are available by calling Provider Services at 1-866-918-1595.

Member rights and responsibilities can be found on the Health Plan website, [www.upmchealthplan.com](http://www.upmchealthplan.com).



## Closer Look at Changing Health Plans for Medical Assistance Members

Members on Medical Assistance who want to change health plans should call HealthChoices at 1-800-440-3989 if they reside in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, or Westmoreland county. TTY users should call 1-800-618-4225. Medical Assistance members in Bedford, Clearfield, Crawford, and Mercer counties should call Member Services at 1-800-286-4242.

# Identifying Members and Verifying Eligibility

Providers have several methods to identify a Health Plan member and verify their eligibility. Some of these methods are:

## Identification Card

Each member receives an identification card, which can be used only by the person listed on the card. Use of a member's card by another person is insurance fraud and is grounds for the member's termination from the Health Plan.

- ▶ See *Provider Standards and Procedures* chapter, *Reporting Fraud and Abuse*, chapter B.
- ▶ See *Member ID Cards*, chapter I.

Enrollment forms for newborns and adopted children must be submitted within the first 31 days of life or placement. The child will receive an ID card within 14 days after that.



### Alert—Member ID Cards

Possession of a member ID card does not guarantee eligibility. Providers must request any and all insurance cards from the member before performing services. Providers should verify UPMC Health Plan eligibility by going online at [www.upmchealthplan.com](http://www.upmchealthplan.com), by calling the Interactive Voice Response (IVR) system at 1-866-406-8762, or by calling Provider Services at 1-866-918-1595.



### Alert—Medical Assistance ACCESS Card

Possession of an ACCESS card does not guarantee eligibility. UPMC *for You* members may become ineligible for Medical Assistance or may opt to change their medical plan at any time. Providers must verify Medical Assistance and UPMC *for You* eligibility.

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## Online

The Health Plan offers providers the ability to verify eligibility by going online at [www.upmchealthplan.com](http://www.upmchealthplan.com). This website requires a user ID and password. To view information about an eligible member, providers need either the member's home telephone number or ID number. The database then reveals the member's benefits, including riders, and the date such benefits take effect.

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### Closer Look at Verifying Eligibility Online

- At a minimum, providers need the following hardware and software to use the provider portion of the Health Plan website to verify eligibility:

#### Hardware

- Pentium class computer (500MHz) with 64 MB RAM or better
  - Video display resolution of at least 800x600 using small fonts
  - 56k modem or better (or other method for Internet connectivity)
- Software
    - Microsoft Windows 98SE or better
    - Microsoft Internet Explorer 5.5 with 128 bit encryption strength

To find out more about how to use the Health Plan's website to verify eligibility or to set up an account, please call **UPMC Health Plan** Web Services at 1-800-937-0438 from 8 a.m. to 4:30 p.m., Monday through Friday.

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## Provider Services

To verify whether a member's card is valid, call the appropriate Provider Services line from 8 a.m. to 5 p.m., Monday through Friday:

UPMC Health Plan (Commercial) 1-866-918-1595 UPMC *for Kids*—1-800-650-8762 UPMC *for You* (Medical Assistance) 1-800-286-4242 UPMC *for Life* (Medicare) 1-877-539-3080 UPMC *for Life* Specialty Plan 1-800-606-8648

Providers also may call the Interactive Voice Response (IVR) system at 1-866-406-8762 to verify member eligibility.

### For UPMC *for You* (Medical Assistance) Members Only

Providers may call DPW's Electronic Verification System (EVS) at 1-800-766-5387 to determine whether the member is eligible on the date of service.

#### *EVS Swipe Box*

Providers may use the Medical Assistance EVS "swipe box" and the member's Pennsylvania ACCESS card. EVS machines can be obtained by calling 1-800-248-2152.

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### Alert—EVS Swipe Boxes

UPMC *for You* cards do not activate DPW's EVS machines.

*DPW's Online PROMISe System*

Medical Assistance participating providers also may verify eligibility by using DPW's online PROMISe system.

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### Alert—Verification of Eligibility

Checking the member eligibility report or verifying eligibility does not constitute prior authorization or guarantee claim payment, nor does it confirm benefits or exclusions. Members must acknowledge in writing their financial responsibility before services are provided.

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## Updating Coordination of Benefits (COB) Information

When providers identify that coordination of benefits or other insurance coverage information for a member is missing or incorrect, they should notify the Health Plan immediately via the website at [www.upmchealthplan.com](http://www.upmchealthplan.com) or contact Provider Services.

UPMC Health Plan (Commercial)	1-866-918-1595
UPMC <i>for Kids</i>	1-800-650-8762
UPMC <i>for You</i> (Medical Assistance)	1-800-286-4242
UPMC <i>for Life</i> (Medicare)	1-877-539-3080
UPMC <i>for Life</i> Specialty Plan	1-800-606-8648

To assist with timely and accurate processing of COB claims and minimize adjustments and overpayment recoveries, the Health Plan requires the following information:

- Insured ID number
- Insured name
- Subscriber name
- Relationship to member
- Other insurance name
- Other insurance phone
- Other insurance address
- Effective date of coverage
- Term date of coverage, if applicable
- Type of coverage (e.g., medical, dental, auto insurance, hospital only, vision, worker compensation, major medical, prescription, or supplemental)

# Determining Primary Insurance Coverage

## For UPMC Health Plan (Commercial) Members

These guidelines will help providers determine primary insurance coverage for their commercial members.

If a member is covered under two group health plans, one as the employee and the other as the spouse of an employee...  
...the group health plan covering the member as a subscriber or a retiree is primary. The group health plan covering the member as a dependant is secondary.

If a member is a subscriber on more than one group health plan...  
...the plan that has been active the longest is the primary health insurance carrier.

If a member has any type of Medical Assistance coverage...  
...the Health Plan's commercial insurance is always primary over Medical Assistance. Group health plan copayments never should be collected for any service, including prescriptions. The provider is permitted to collect the Medical Assistance copayment, if applicable, for any service covered by Medical Assistance.

Medical Assistance is always the payer of last resort. If the member has more than one commercial insurance carrier or has Medicare and commercial insurance, other rules regarding coordination of benefits apply.

▶ [See UPMC for You Members, chapter I.](#)

If a woman has a baby...  
...the newborn is covered under the mother's benefits using the mother's identification number for the first 31 days of life. If the mother does not have insurance, the baby is covered under the father's benefits, using the father's identification number, for the same period. The Health Plan subscriber (the mother or the father) must add the newborn to the family plan within the first 31 days of life by submitting a completed enrollment form to the subscriber's employer. The selected primary care office for the newborn must be indicated on the form, if applicable. For the first 31 days, if the newborn is covered under both parents, other coordination of benefits rules may apply. A child born to a Medicare Advantage member is covered for the first 31 days under the mother's benefits.

If a child is adopted...

...the child is covered using the mother's ID number for the first 31 days following placement. A similar procedure to that for newborns must be followed.

If a child has dual coverage from both parents who are not legally separated or divorced...

...the child's primary insurance carrier is the parent or guardian whose birth date falls earlier in the calendar year. (This is known as the "birthday rule.")

If a child has dual coverage from both parents and the parents are divorced or separated...

...the child's primary insurance carrier is the plan of the parent who has custody of the child or as indicated by court order. The secondary insurance carrier would be the plan of the spouse of the parent with custody. The tertiary insurance carrier would be the plan of the parent who does not have custody. The quaternary insurance carrier would be the plan of the spouse of the parent without custody.

Court decree exception: If a court decree makes the non-custodial parent responsible for the child's health care or for providing health insurance, the non-custodial parent's plan is primary.

Joint custody situations: If a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage, the birthday rule is followed. (i.e., Coverage is through the parent or guardian whose birth date falls earlier in the calendar year.)

If a member is laid off or retired...

the plan that covers a person as an employee (or that employee's dependant) who is neither laid off nor retired is primary.

If a member has UPMC Health Plan as secondary insurance and the primary insurance carrier authorizes coverage for a service or procedure for which UPMC Health Plan requires prior authorization...

...then authorizations/PCP referrals are not required. If the primary carrier authorized but did not pay the service, the provider must appeal with the primary carrier. The provider must comply with all primary insurance carrier requirements for the claim to be considered by UPMC Health Plan as the secondary carrier.

If a UPMC Health Plan member is 65 or older and is covered through current employment or a spouse's current employment and also has Medicare coverage...

...Medicare is primary if the employer has fewer than 20 employees. UPMC Health Plan is primary if the employer has 20 or more employees.

If a UPMC Health Plan member has Medicare due to a disability, is under age 65, and also has coverage through current employment or a family member's current employment and also has Medicare coverage...

...Medicare is primary if the employer has fewer than 100 employees and is not part of a multi-employer plan where any one employer has more than 100 employees. UPMC Health Plan is primary if the employer has 100 or more employees.

If a UPMC Health Plan member also is covered under Medicare because of end-stage renal disease (ESRD) ...

... UPMC Health Plan is primary for the first 30 months of eligibility or entitlement to Medicare. Medicare is primary following a 30-month coordination period with a commercial health plan.

If a UPMC Health Plan member is covered under workers' compensation because of a job-related illness or injury...

...workers' compensation is primary for all workers' compensation-related services.

If a UPMC Health Plan member has been in an accident where no-fault or liability insurance is involved...

...no-fault or liability insurance is primary for all accident-related services.

## For UPMC *for You* (Medical Assistance) Members

If a UPMC *for You* member has additional health insurance coverage, UPMC *for You* is, in most cases, the payor of last resort.

### **ALERT!**

It is a Federal requirement (42 CFR 457.350) that State CHIP coverage is provided only if the child is ineligible for Medical Assistance (MA). Any overlapping period with both CHIP and MA coverage should be covered by MA. In this instance, CHIP is the payor of last resort. UPMC Health Plan's CHIP product is known as UPMC *for Kids*. See Chapter D for more information regarding the UPMC *for Kids* product.

UPMC *for You* acts as the primary carrier for EPSDT screens, obstetrical claims, and family planning services, regardless of other coverage. If, however, an EPSDT screen is received with another carrier's EOB, UPMC *for You* will coordinate benefits.

▶ See *Medical Assistance* chapter, EPSDT program, chapter E.

If a member has two or more policies, additional guidelines may apply.

▶ See *For UPMC Health Plan (Commercial) Members*, chapter I.

▶ See *For UPMC for Life (Medicare) Members*, chapter I.

If other insurance is primary, UPMC *for You* requires documentation of the other payor's payment or non-payment of the claim (e.g., the explanation of benefits or the explanation of payment).

At the time of service, providers should make reasonable efforts to obtain from the UPMC *for You* member all information regarding other insurance.

If a woman has a baby...

...the newborn is covered by UPMC *for You* for the first 31 days of life if the mother is a member of UPMC *for You* on the newborn's date of birth. If the mother has other primary insurance on the newborn's date of birth, the primary insurance carrier is responsible for the newborn for the first 31 days of life. The mother must add the newborn to her UPMC *for You* coverage within the first 31 days of life by following the appropriate procedures established by the Department of Public Welfare.

If a child is adopted...

...the child is covered by UPMC *for You* for the first 31 days following legal placement with an adoptive parent who is a member of UPMC *for You* on the day of the legal placement. The adoptive parent must add the newborn to his or her UPMC *for You* coverage within the first 31 days of legal placement by following the appropriate procedures established by the Department of Public Welfare.

Exceptions may apply when the child is in the custody of Children and Youth Services.

## For UPMC *for Kids* (CHIP) Members

UPMC *for Kids* members cannot have additional health insurance coverage. If they are found to be active on private coverage, then CHIP coverage will be retro terminated to avoid an overlap in coverage (e.g. if a CHIP member obtains private insurance coverage beginning on June 1, that member would terminate from CHIP on June 1. So, the member's last day of CHIP coverage would be 5/31.)

In addition, it is a Federal requirement (42 CFR 457.350) that State CHIP coverage is provided only if the child is ineligible for Medicaid. Any overlapping period with both CHIP and Medical Assistance coverage should be covered by Medical Assistance. In this instance, CHIP is the payer of last resort.

At the time of service, providers should make reasonable efforts to obtain from the UPMC *for Kids* member, all information regarding other insurance.

**If a woman has a baby...**

... the newborn is covered by UPMC *for Kids* for the first 31 days of life if the mother is a member of UPMC *for Kids* on the newborn's date of birth. For coverage to continue beyond this initial period, the head of the household must add the newborn to the UPMC *for Kids* coverage within the first 31 days of life by calling UPMC *for Kids* Member Services at 1-800-650-8762. TTY users should call 1-800-361-2629.

**If a child is adopted...**

...the adoptive parent(s) must call UPMC for Kids Member Services and have the child added to the CHIP application. Annually, at renewal, the household will be reassessed for eligibility based on the new household size to determine what CHIP program the children qualify under: Free, Low-Cost, or Full-Cost coverage.

## For UPMC *for Life* Members

Typical scenarios providers may encounter include the following:

If a UPMC *for Life* member has any type of Medical Assistance coverage...

...UPMC *for Life* is primary to the Medical Assistance coverage. Members may transfer in or out of this "dually eligible" status month to month. The provider is permitted to collect the Medical Assistance copayment, if applicable, for any service that is covered by Medical Assistance.

If a UPMC *for Life* member presents a traditional Medicare card and a UPMC *for Life* identification card...

...UPMC *for Life* is primary. Members must show both identification cards to the provider.

If a Medicare Select member presents a traditional Medicare card and a Medicare Select card...

...Medicare is primary. Members must show both identification cards to the provider.

If a UPMC *for Life* member is 65 or older and also covered by a group health plan because of current employment or spouse's current employment...

...UPMC *for Life* is primary if the employer has fewer than 20 employees. The group health plan is primary if the employer has 20 or more employees.

If a UPMC *for Life* member is eligible for Medicare because of disability, is under age 65, and is covered by a group health plan from current employment or a family member's current employment...

...UPMC *for Life* is primary if the employer has fewer than 100 employees and is not part of a multi-employer plan where any one employer has more than 100 employees. The group health plan is primary if the employer has 100 or more employees.

If a UPMC *for Life* member is eligible for Medicare because of end-stage renal disease (ESRD) and also has group health plan coverage...

...the group health plan is primary for the first 30 months of eligibility or entitlement to Medicare. UPMC *for Life* is primary after a 30-month coordination period.

If a UPMC *for Life* member is covered under workers' compensation because of a job-related illness or injury...

...workers' compensation is primary for all workers' compensation-related services.

**Member Administration**

Determining Primary Insurance Coverage

If a UPMC *for Life* member has been in an accident where no-fault or liability insurance is involved...

...no-fault or liability insurance is primary for all accident-related services.



### Closer Look at Collecting Payment

Providers may not collect a copayment from a member who has UPMC *for Life* as primary coverage and any type of Medical Assistance as secondary coverage. The provider is permitted to collect the Medical Assistance copayment, if applicable, for any service that is covered by Medical Assistance.

Providers also should not collect payment at the time of service from a member with Medicare Select. Instead, providers should bill the member for any deductibles or copayments after payment is received from the Health Plan.

# Selecting or Changing a Primary Care Provider

## Selecting a Primary Care Provider

All HMO members, including commercial, UPMC *for You*, UPMC *for Kids*, and UPMC *for Life*, must select a PCP. If a member does not select a PCP, the Health Plan will either help a member select a PCP or assign one.

Members who have an Enhanced Access Point-of-Service (EAPOS) plan are encouraged to select a PCP, but they are not required to have a designated provider.

Commercial members with Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) plans as well as Medicare Select and UPMC *for Life* PPO (Medicare Advantage) members do not select a PCP.

## Changing a PCP

Commercial members who would like to change PCPs may go online to [www.upmchealthplan.com](http://www.upmchealthplan.com) or contact **Member Services** at **1-888-876-2756** Monday through Friday, from 8 a.m. to 8 p.m., and on Saturday from 8 a.m. to 3 p.m.

Members who belong to the following products must contact Member Services (number is listed) to change their PCP:

UPMC *for Kids* - 1-800-650-8762

UPMC *for You* – 1-800-286-4242

UPMC *for Life* and UPMC *for Life Specialty Plan* – 1-877-539-3080

Once the request is received and processed, it takes effect immediately. The member will receive a new ID card indicating the new PCP.

## Restricted Recipients

DPW and UPMC *for You* maintain a restricted recipient program to identify and manage members who are mis-utilizing medical services or pharmacy benefits. These members are restricted to specific PCPs, pharmacies, and/or facilities in order to monitor and prevent mis-utilization.

## Selecting a Specialist as a Member's PCP Commercial and UPMC *for Life* (Medicare Advantage) Members

A member may not select a specialist as a PCP unless that specialist is also credentialed by the Health Plan as a PCP.

- ▶ See *Provider Standards and Procedures* chapter, *Dual Credentialing and Re-credentialing as a PCP and Specialist*, chapter B.

## UPMC *for You* (Medical Assistance) Members

UPMC *for You* members with a threatening, degenerative, or disabling condition may be permitted to select a specialist as their PCP. The member is permitted to have this specialist provide primary care and coordinate specialty care; however, the specialist must agree to these responsibilities, which include being available for emergencies 24 hours a day, 7 days a week. The specialist must sign an agreement and go through the credentialing process again. The member must make a formal request to Special Needs at 1-800-286-4242. UPMC *for You* then contacts the specialist to see if he or she is willing to be the member's PCP.

The Health Plan will contact the specialist once the credentialing process is complete, which takes 2 to 6 months. The specialist should then inform the member that he or she is able to serve as the member's PCP.

- ▶ See *Provider Standards and Procedures* chapter, *Dual Credentialing and Re-credentialing as a PCP and Specialist*, chapter B.

# Removing a Member from a Provider's Practice

The Health Plan realizes that, at times, an optimal provider-patient relationship cannot be established. If circumstances require that a provider remove a member from a practice, please follow these steps:

1. Determine why a patient should be removed from the practice.
2. Draft and send letters indicating these reasons to the member and to Member Services.

UPMC Health Plan\*  
Member Services Department  
One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219



## Closer Look at Providing Care After Sending Letter

Primary care providers must provide care for 30 days from the date of the letter submitted to the Health Plan.

Member Services will notify the member, assist him or her in selecting a new PCP, and determine the effective date of change.

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3. Transfer or copy the member's medical records.  
Providers should transfer records at no charge to the member within 7 business days of being informed of the identity of the new provider.

\*Please indicate UPMC *for You* or UPMC *for Life*, if applicable, on the envelope.