

# UPMC *for Kids*



- D.2** [At a Glance](#)
- D.4** [Covered Benefits](#)
- D.13** [Benefit Exclusions](#)
- D.14** [Member Complaint and Grievance Procedures](#)
- D.19** [Member Rights and Responsibilities](#)
- D.21** [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 that provides 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, dental (orthodontia, when medically necessary), 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 tobacco cessation counseling, nutrition counseling, the MyHealth Advice Line, MyHealth OnLine, and health promotion programs.

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 *full-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 type of CHIP coverage a family has may change based on the family's income, and this may impact copayments. 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*. 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**, from 8 a.m. to 5 p.m., Monday through Friday.

## 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 years) are covered.
- Most preventive services are fully covered.
- Obstetrician-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:
    - 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:
    - Outpatient physical health (sick and follow-up visits to PCPs, specialist visits, and outpatient surgery)
    - Outpatient mental health
    - Outpatient substance abuse rehabilitation
    - Outpatient occupational, physical, and speech therapy
    - Home health
    - Hearing exams and aids
    - Durable medical equipment
    - Tobacco cessation counseling
    - Dental care
    - Vision care

# Covered Benefits

## At a Glance

UPMC *for Kids* network PCPs, specialists, therapists, 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, which is 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 services (as listed above)
- 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, go to [www.upmchealthplan.com](http://www.upmchealthplan.com).

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

► See *Quick Reference Guide, UPMC for Kids, 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 to determine if the equipment is covered, and if prior authorization is required. Refer to the Quick Reference Guide to determine which equipment requires prior authorization.

▶ See *Quick Reference Guide, UPMC for Kids, Chapter D.*

---

## 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 approved prior to admission and will only be considered if the service cannot be performed at a participating hospital.

▶ See *Quick Reference Guide, UPMC for Kids, 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 hospital admissions:**

- All of these types of admissions are subject to a combined maximum limit of 90 days per plan year. If a member utilizes his or her entire outpatient mental health visits within a plan year, he or she may exchange some of the inpatient mental health days for intensive outpatient, 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.

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.

### **Autism Spectrum Disorders**

UPMC *for Kids* covers all eligible members for the diagnostic assessment and treatment of autism spectrum disorders. The following services, when medically necessary for the assessment/treatment of autism spectrum disorders, are covered:

- Prescription drug coverage;
- Services of a psychiatrist and/or psychologist; and
- Rehabilitative care and therapeutic care.

Coverage for autism spectrum disorders is limited to a maximum benefit of \$36,000 per member per plan year. Coverage under this section shall be subject to copayment and any other general exclusions or limitations.

Treatment of autism spectrum disorders must be:

- Identified in a treatment plan.
- Prescribed, ordered, or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker, or certified registered nurse practitioner.
- Provided by an autism service provider or a person, entity, or group that works under the direction of an autism service provider.

The following definitions apply to this benefit:

- Autism Service Provider - means any of the following:
  - A person, entity, or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is licensed or certified in the Commonwealth of Pennsylvania; and

- Any person, entity, or group providing treatment of autism spectrum disorders, pursuant to a treatment plan, that is enrolled in the Commonwealth of Pennsylvania's Medical Assistance program on or before July 1, 2009.
- Autism Spectrum Disorders:
  - Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.
- Treatment Plan:
  - A plan for the treatment of autism spectrum disorders developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

## Dental Benefits

Avesis Third Party Administrators, Inc., administers dental benefits for UPMC *for Kids* members. Routine and restorative dental care is a covered benefit when performed by an Avesis participating dentist. All preventive, diagnostic, and other dental services are limited to a maximum of \$1,500 per member per calendar year. Diagnostic and preventive services such as oral exams, cleanings, and x-rays are covered benefits and do not require prior authorization. Other services may require prior authorization.

Providers may call **Avesis provider services** directly at **1-888-209-1243**. Members may call **Avesis member services** directly at **1-888-257-0350** from 7 a.m. to 8 p.m., Monday through Friday. TTY users may call toll-free at **1-800-361-2629**.

## Orthodontia

Orthodontia, when medically necessary, is covered and requires a prior authorization. Benefits include evaluations, placement, adjustments, retainers, and removal of braces. Comprehensive orthodontia services have a lifetime limit of \$5,200 per member.

## 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 Avesis dental provider. If oral surgery is performed under the medical benefit, some members may have copayments.

## 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, UPMC for Kids, 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. Outpatient physical health visits are limited to 50 visits per plan year, including visits to specialists, sick or follow-up visits to the PCP or specialist, and outpatient surgery. 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
- Allergy injections

Hearing services, including:

- Hearing aids and fittings are limited to one per ear, every two 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 someone with an average knowledge of health and medicine could reasonably 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 member 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

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 UPMC Health Plan Behavioral Health Services at **1-888-251-2224**.



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**

Medically necessary outpatient surgery is covered when provided at a participating UPMC *for Kids* facility and when coordinated by the member's PCP (when applicable), ob-gyn, or network specialist. Some procedures may require prior authorization.

▶ See *Quick Reference Guide, UPMC for Kids, 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 nutritional therapy:
  - Provided by a dietitian or facility-based program, when ordered by a physician for certain diagnoses to treat chronic illness or conditions
- Medical therapy services, including:
  - Chemotherapy
  - Dialysis
  - Infusion therapy
  - Radiation therapy
  - Respiratory therapy

- Nutritional counseling:
  - Provided by a dietitian or facility-based program, when ordered by a physician 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.

- ▶ See *UPMC for Kids Pharmacy Program drug benefit information, Pharmacy Service, Chapter J.*

### **Routine Vision Benefits**

OptiCare Managed Vision administers routine vision benefits for UPMC *for Kids* members. Members must use a participating OptiCare vision provider. Members may self-direct care. Vision benefits include:

- 1 routine eye exam once in a 12-month period:
  - Allowance of \$100 for prescription lenses and frames or contact lenses (including the lenses fitting)
  - Charges exceeding the \$100 allowance are the responsibility of the member

Providers and members may call **OptiCare** directly at **1-866-921-7965** from 8 a.m. to 7 p.m., Monday through Friday.



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

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

## **Urgent Care Visits**

An urgent medical condition is any illness, injury, or severe condition which, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become a crisis or emergency medical condition.

Some members have a copayment for urgent care visits, which is the same as the copayment for a specialist visit.

## **Out-of-Area Urgent Care**

Coverage is provided if a member is traveling outside the UPMC *for Kids*' service area and has an urgent medical condition that requires medical attention before returning to the area. An urgent medical condition is any illness, injury, or severe condition which, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become a crisis or emergency medical condition.

Additionally, it includes situations in which a person's discharge from a hospital would be delayed until services are approved, or in which a person's ability to avoid hospitalization depends upon prompt approval of services. Routine care is not covered outside the UPMC *for Kids*' service area. Some members have a copayment for out-of-area urgent care visits, which is the same as the copayment for a specialist visit.

## **Women's Care**

Benefits for women's preventive care include an annual Pap test, annual gynecological exam, and clinical breast examination from a network provider. 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
- 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 filed when a member's parent or guardian is dissatisfied with services a member received from UPMC *for Kids* or their provider, payment of services, or benefit structure. A member's parent or guardian must file a complaint within 180 days from the date of the event.

## What Should a Member's Parent or Guardian Do if He or She Has a Complaint?

Parents or guardians 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 individuals should call **Member Services** at **1-800-650-8762** to be connected with our contracted language translation services representatives.

At any time, the member's parent or guardian may appoint in writing a representative to act on their behalf when filing a complaint. The member's parent, guardian, or representative also may request the aid of a UPMC Health Plan employee who has not participated in the previous decision to deny coverage.

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

## What if a Member's Parent or Guardian Is Still Unhappy with the Decision?

A member's parent or guardian who is 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's parent or guardian receives written notice on the First-Level Complaint decision. Parents or guardians of members and/or their appointed representative will have 15 days' advance notice of the date and time of the review meeting. Parents or guardians have the right to meet with the Second-Level Committee in person or by telephone. The Second-Level Review is conducted within 30 calendar days from the receipt of the request for a Second-Level Complaint. A member's parent or guardian will be notified by mail within 5 business days after the Second-Level Complaint Committee reaches a decision.

## **What Can a Member's Parent or Guardian Do if He or She Does Not Like the Decision of the Second-Level Committee?**

Parents or guardians 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 912  
625 Forster Street  
Harrisburg, PA 17120-0701  
1-888-466-2787  
TTY: 1-800-654-5984**

or

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

## **What Is a Grievance?**

A grievance is filed when a member's parent or guardian is 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 Does a Member's Parent or Guardian Initiate a First-Level Grievance?**

When UPMC *for Kids* issues a denial, decreases a service, or approves a service different from the service requested, a member's parent or guardian will receive a letter informing him or her about the grievance process. The grievance process has two steps: First-Level Grievance and Second-Level Grievance. Parents or guardians have the right to participate in the Second-Level Grievance review.

A member's parent or guardian must file a grievance within 180 days upon receipt of the notice from UPMC for Kids. Parents or guardians 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 parents or guardians should call **Member Services** at **1-800-650-8762** to be connected with a contracted language translation services representative.

At any time, the member's parent or guardian may appoint in writing a representative to act on his or her behalf when filing a grievance. The member's parent, guardian, or representative also may request the aid of a UPMC Health Plan employee who has not participated in the previous decision to deny coverage.

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



The member's parent or guardian 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's parent or guardian a decision letter within 5 business days after the First-Level Grievance review is completed. This letter will inform the member's parent or guardian of the reason for the decision and how to file a Second-Level Grievance, which must be filed 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 be either a licensed dentist or licensed physician. The member's parent or guardian and the member's

provider may participate in the Second-Level Grievance Committee meeting in person or by telephone. Parents or guardians of members and/or their appointed representative will have 15 days of advanced notice of the date and time of the meeting.

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

### **External Grievance Procedure**

After a member's parent or guardian exhausts the Internal Grievance Process, they may request an External Grievance through the Pennsylvania Department of Health by sending a letter to the UPMC *for Kids* Complaints and Grievances Department at:

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

Parents or guardians 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's parent or guardian 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's parent or guardian in writing of the decision within 60 calendar days of filing the External Grievance.

### **Expedited Complaints and Grievances**

If a provider believes the usual time frames for deciding a member's complaint or grievance will harm his or her health, the member's parent or guardian can call **Member Services** at **1-800-650-8762** and request that the complaint or grievance be expedited or send a letter to:

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

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's parent or guardian of its decision.

---

### **Expedited External Review**

Upon receipt of the Expedited Internal Review decision, a member's parent or guardian has two 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 two business days and notify the member's parent or guardian 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 UPMC 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 the child's rights and responsibilities
- To be treated with respect and recognition of the child's dignity and right to privacy
- To participate with practitioners in decision making regarding the child's health care
- To receive clear and complete information from the child's doctor about the child's health condition and treatment
- To participate in a candid discussion of appropriate or medically necessary treatment options for the child's condition, regardless of cost or benefit coverage
- To voice complaints, grievances, or appeals about UPMC Health Plan, the care provided, or the child's practitioner or provider
- To choose the child's practitioner or provider from the list of network providers and to receive timely care in an emergency
- To see the child's medical records, to obtain copies, and to have corrections made, if needed
- To have the child's medical information kept confidential whether it is in written, oral, or electronic format
- To make decisions about the child's treatment, including the right not to participate in research, and to refuse treatment, as long as it is understood that by refusing may cause the child's health problem to get worse or possibly become fatal
- To make recommendations regarding UPMC 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 the member or the parents or guardians, and for purposes other than treatment, payment, and operations (TPO)

## Responsibilities

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

- To provide a safe environment for services rendered in the child or parent/guardian's place of residence
- To pay any applicable fees

## *Quick Reference Guide*

The quick reference guides are available in the Medical Management tab on Provider OnLine at [www.upmchealthplan.com/providers/medmgmt.html](http://www.upmchealthplan.com/providers/medmgmt.html)

Hard copies are available upon request. Please contact UPMC *for Kids* **Provider Services** at **1-800-650-8762** from 8 a.m. to 5 p.m., Monday through Friday.