Provider Reference Manual

Select Health Commercial and Government Plans

January 2025

Select Health

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1.0 Introduction

Contact or access information: These notes typically appear in a box in the left-hand column of the page, similar to this:

Questions? Contact the Select Health Recovery Team at **801-442-5687** in Salt Lake City or **800-538-5038, ext. 5687** elsewhere in the continental United States.

* For members on Select Health Medicare plans (Advantage plans), review the information in **Appendix A**.

Medicare/Medicaid Cross References: When a topic in this manual has Medicare/Medicaid plan-specific information in the appendices, you will see a reminder like the example **above** in the left-hand column next to the topic. Note that these cross references always appear in a colored box.

The Select Health Provider Reference Manual is intended for use by physicians, ancillary providers, and contracted facilities/vendors as well as their practice managers and office staff. The manual offers, in conjunction with **selecthealth.org/providers** website, a reference guide for education, training, and navigating Select Health policies and procedures for commercial and government plans. We use cross referencing for any topic that is detailed in the appendices covering Medicare, Medicaid, and CHIP.

Using the Manual

To navigate the manual quickly, please note:

- Main topics apply to all plans and are arranged alphabetically. See note at left about information specific to government plans.
- Each entry in the Table of Contents is linked to the page where that section begins.
- By clicking on the Select Health logo on any page in the manual, you can return to the Table of Contents to access other sections.

The information communicated in this manual does not take the place of the physician service agreement signed by the contracted or employed provider. The term "provider" is used interchangeably in referring to physicians, mental health professionals, rehabilitation providers, contracted facilities/vendors as well as other contracted providers.

Information specific to providers on Medicare and Medicaid plans listed below can be found in the appendices to this manual:

- **Select Health Medicare® (Medicare):** Begins on **page 47**
- **Select Health Community Care® (Medicaid):** Begins on **page 63**

Children's Health Insurance Program (CHIP) topics are identical to those for all other plans.

Additional Manuals

We maintain separate Provider Reference Manuals for dental and pharmacy providers as well as for credentialing policies and procedures. All manuals can be accessed at **https://selecthealth.org/providers/publication-resources/prm**.

Updates to Select Health Provider Reference Manuals

All provider reference manuals are reviewed and updated regularly as information changes in any section. Access the most recent version at **https://selecthealth.org/providers/publication-resources/prm**.

Select Health is committed to our provider partners. We thank you for your continued participation in our network(s) and the service you provide our members.

1.1 Privacy Notification

Our **Notice of Privacy Practice** is available online (there is also a link on the footer of every page in the **selecthealth.org/providers** website). You can request a hard copy of this information by contacting the Intermountain Privacy Office at **800-442-4885**, **privacy@imail.org**, or by writing to the following address:

Select Health
Attention: Privacy Office
P.O. Box 30192
Salt Lake City, UT 84120-8212

1.2 Benefits and Responsibilities of Participation

Benefits for providers contracted with Select Health are:

- Being listed in provider directories on the Select Health website
- Having patients referred to them by Select Health Member Advocates
- Direct payment for submitted claims
- Select Health Provider Relations representatives available to assist providers and their office staff
- Select Health member claims paid as a preferred benefit

Responsibilities of Select Health and contracted providers include:

- Select Health members being directed to facilities and other healthcare providers who participate on Select Health panels, whenever possible
- Providers not billing the member for covered services provided to the member, as specified in the Select Health Participating Provider Services Agreement
- Members not being asked to submit their own claims
- Providers making a copy of medical records available when requested for claims processing and payment
- Providers accepting the Select Health Maximum Allowable Fees as payment in full for covered services for Select Health members

Access Standards

2.1 Medical Access Standards

Life-Threatening Medical Problems. Members with life-threatening medical problems will have access to acute medical care with participating or nonparticipating providers 24 hours a day, seven days a week.

Urgent/Acute Medical Problems. Members with urgent/acute (but not life threatening) medical problems will have access to specialty-appropriate medical services with participating or nonparticipating providers within 24 hours of the request of service.

Non-urgent/Non-Acute Medical Problems. Members with non-urgent/non-acute medical problems will have access to a specialty-appropriate participating provider **within seven calendar days** of the request of service.

Well-Person Care or Chronic Illness Routine Evaluations. Members who need well-person care or chronic illness routine evaluations will have access **within 21 calendar days** of the request for service for:

- Specialty-appropriate participating providers and facilities
- Well newborns younger than one month of age

This standard **does not** apply to routine eye refractions or hearing screens.

Waiting Room Standards. Providers will see the patient within an average of 30 minutes after the patient's arrival for an office visit.

Equal Access. Participating providers or their designees (primary care and specialty) will be available for telephone consultation to members in a fashion consistent with the access granted by the provider for their patients who do not have Select Health insurance.

24-Hour Physician Availability. Providers or their comparable covering designees will be available by telephone for emergent and/or urgent situations 24 hours a day.

2.2 Behavioral Health Access Standards

Life-Threatening Problems. Members with life-threatening behavioral health problems (crisis) will have access to acute medical care with participating or nonparticipating providers 24 hours a day, 365 days of the year. A crisis is defined as persons presenting with acute symptoms of immediate, actual, or potential danger to self, others, or property. Providers should direct members to an emergency room (ER) or a behavioral health crisis center if they are experiencing a behavioral health emergency.

Non Life-Threatening Problems. Members with non life-threatening emergent behavioral health problems will have access to care within six hours. A non life-threatening emergent behavioral health problem is defined as persons not at risk to harm themselves or others. However, if the problem is left unattended, it would exacerbate into a crisis.

Urgent Problems. Members with urgent behavioral health problems will have access to care within 48 hours.

NOTE: These access requirements apply to members in Utah and in some other markets.

If you are outside of Utah, contact your Provider Relations representative for details.

Routine Problems. Members with routine behavioral health problems will have access to care within 10 business days.

Waiting Room Standards. Providers will see the patient within an average of 30 minutes after the patient's arrival for an office visit.

Equal Access. Participating providers or their designees will be available for telephone consultation to members in a fashion consistent with the access granted by the provider for their patients who do not have Select Health insurance.

24-Hour Physician Availability. Providers or their comparable covering designees will be available by telephone for emergent and/or urgent situations 24 hours a day.

2.3 Monitoring Patient Access

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Select Health will monitor member access to care using the following methods:

- **Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey**. The CAHPS Survey will be used to measure compliance with accessibility to the following services:
  - Urgent medical health problems
  - Non-urgent regular or routine medical problems
- **CAHPS Experience of Care and Health Outcomes (ECHO) Survey**. Select Health uses this survey to ask health plan enrollees about their experiences with behavioral health care and services.
- **Member Calls**. Select Health monitors calls to Member Services or the Select Health Member Advocates® team regarding access or service problems. Such inquiries or complaints are tracked and reported to the Quality Improvement committee to identify access barriers.
- After-hours access survey.
- Medical and behavioral health failed access and service approval reports.
- Appointment wait-time surveys.
- Adequacy for time and distance from member to provider and measuring provider to member ratios through Milliman data.
- Other methods as appropriate.

3.0 Auto Recovery

Automatic (Auto) Recovery is the process Select Health uses to reverse and adjust claims paid in error rather than requesting a refund. All claim lines will be reversed and any denial or repayment will be reprocessed on a new claim.

3.1 What Does Auto Recovery Look Like?

NOTE: Access a **Sample Remittance Advice** and a **Remittance Advice Key** for more information.

The Remittance Advice (RA)/Explanation of Payment (EOP) will reflect a line-by-line reversal of the claim as well as a repayment or denial on a new claim, if necessary. This claim reversal information will appear as a negative in the claim detail section of the RA. The reason for the adjustment will be explained with the remark codes on the reversed claim and/or the reprocessed claim.

The dollar amount associated with the actual recovery is located at the end of the RA in the "Recovery and Forward Balance Detail for This Payment" section. The dollars listed as a "Recovery Amount" should be subtracted from the account as the actual amount recovered on this payment. Any amount listed as a "Forward Balance" was not recovered from this payment and will be recovered from a future payment.

On electronic postings (835), when a claim is paid incorrectly, the original claim will be reversed, and the corrected data will be sent all on the same transaction. The payment and the reversal will post directly to the billing office's system.

Claims will only be auto recovered if there is enough money being paid out to your office to offset (in full or partially) the amount being recovered. If no payment is being made a notification of the recovery will be sent and the amount will appear as a forward balance.

3.2 Future Refund Requests

All claims we adjust will be set up to auto recover from the next payment. There may be times when Select Health may request a refund check instead of being able to auto recover a claim, such as when:

- The address or tax identification number for the office have changed, and payments are no longer being sent to allow a recovery to occur.
- There is not enough payment activity in a timely period to allow a recovery to occur.

3.3 Payment Options and Contact Information

If a refund is requested from your office, you may mail a check to:

Select Health Recovery Team
P.O. Box 27368
Salt Lake City, UT 84127-0368

You may also contact the Recovery Team by phone and make a credit card or check by phone payment to ensure same day posting and avoid a check and recovery crossing in the mail.

Questions? Contact the Select Health Recovery Team at **801-442-5687** in Salt Lake City or **800-538-5038, ext. 5687** elsewhere in the continental U.S.

3.4 Impact of Multiple Internal Select Health Provider ID Numbers

When Select Health creates a new internal provider ID/profile for a provider with a new NPI, TIN, facility name, or address associated, we update the effective date of the profile. All dates of service after that effective date will reprocess and pay again under the new internal profile, which causes duplicate payments. As such, duplicate payments may be sent and Select Health may need to request a refund check.

When claims reprocess and pay under a new profile, we are unable to auto recover and wash out balances due from the old profile under which the claims originally processed. This occurs because the recoveries/payments cannot cross internal provider IDs/profiles.

4.0 Care Management

Treating a Select Health member and think a care manager could help? Please call our Care Management department at **800-442-5305, option 2**.

Select Health provides care management services for Select Health members. Care managers are nurses and social workers who take a proactive, holistic approach to helping members meet health goals. They work closely with providers to support treatment goals. Members are stratified using analytics to identify those at risk for future avoidable utilization, admissions, readmissions, complex medical needs, and/or social needs. Care managers proactively perform outreach to those with the highest risk and offer services.

Care management focuses on members who repeatedly cycle through the healthcare system without lasting benefit and/or are unable to adhere to a treatment plan without help. We seek to **identify and intervene with members**, such as those who:

- Have medically complex and impactable needs
- Struggle to use healthcare resources appropriately
- Experience comorbid behavioral health and medical conditions or a catastrophic health event (e.g., multiple trauma, new disability)
- Have significant and complex social determinants of health needs
- Experience barriers to care (e.g., access, language)

Care management currently provides:

- Needs assessments performed by a nurse, social worker, care navigator, or community health worker to identify interventions that may impact health and wellness
- Member-centric care plans with identified goals to support providers' plans of care
- Individual member health coaching
- Educational materials specific to member needs
- Referrals to local and online classes (e.g., diabetes, prenatal classes)
- Assistance with obtaining medications, equipment, and supplies
- Help for members to maximize insurance benefits
- Referrals to community-based organizations that can help with identified social determinants of health needs
- A perinatal care management and care coordination program (see section 11.0 Healthy Beginnings for more information)

NOTE: We also support members who have less-complicated health issues but are struggling to manage their health by:

- Coaching for health habits
- Resolving short-term barriers to care
- Helping guide complex referrals to providers and services
- Finding resources

Care management is a vital resource for dealing with the overwhelming stress of **urgent or special medical needs**. Whether it's a new diagnosis or a major injury, specially trained care managers can help members:

- Navigate through the healthcare system
- With self-care by assessing needs and designing and executing a member-centric care plan
- By acting as a liaison between the member and providers to ensure meeting the member's immediate and ongoing needs and that they receive the best possible care.

5.0 Claims Filing Deadlines

NOTE: The filing period can vary per individual provider contract; refer to your specific contract for details. Contact your Provider Relations representative if you have questions.

Claims submitted directly to Select Health for payment to a provider must be submitted to Select Health on UB-92/04 or HCFA 1500 claim forms within **12 months** of the date of service. Claims received by Select Health more than 12 months after the date of service will be denied unless the provider can show that notice was given, or proof of loss was filed as soon as reasonably possible.

Coordination of Benefits (COB) payments (when Select Health is the secondary payer) will be made only if the information supporting the payment is submitted to Select Health within **12 months** after the claim was processed by the primary plan, unless the provider shows that the information was supplied, or proof of loss was filed as soon as reasonably possible.

If a claim is filed to the wrong primary insurer, the claim can be re-filed to the appropriate primary plan within **24 months** of the date of service without penalty. According to the state's COB rule, "A primary plan may not deny payment or a benefit on the grounds that a claim was not timely submitted if the claim was timely submitted to one or more secondary plans and was submitted to the primary plan within 24 months of the date of service."

6.0 Claims Submission

Instead of submitting claims by mail, consider the advantages of submitting them electronically or through your Practice Management Software (PMS). You can send claims electronically through an Electronic Data Interchange (EDI) claims transaction. Electronic claims are typically more accurate and allow us to reimburse you more quickly. And EDI is more than just claims—you can also receive remittance advice, eligibility, and claim status.

6.1 EDI Transactions

Need help with electronic submission? Contact our EDI team by phone or via email:

- **Phone: 800-538-5099**
- **Email:** edi@selecthealth.org

Electronic Data Interchange (EDI) can make your practice more efficient and provide a secure way to send and receive information. EDI transactions are sent via a secure connection through the Utah Health Information Network (UHIN). Rather than sending claims through the U.S. Postal Service or taking the time to call Member Services, EDI X-12 transactions deliver results within seconds. You can also request batch information for most payers.

For payers that participate with UHIN, you can receive benefits and eligibility information on your next day's scheduled appointments in one transaction. Find more information on EDI transactions (including links to online forms and companion guides) at **https://selecthealth.org/providers/claims/edi**.

NOTE: Click the **Electronic Remittance Advice (ERA or 835)** and **Electronic Funds Transfer (EFT)** forms to submit.

6.2 Manual Transactions

Providers can submit paper claims on a CMS 1500 form (version V02.12) for medical professional services or a UB-04 form for hospital/facility billing.

Billing requirements for Select Health Medicare® can be found at **cms.gov**. Claims should be mailed to:

Select Health Medicare
P.O. Box 30196
Salt Lake City, UT 84130-0196

7.0 Code of Conduct (Ethics)

Every day, patients, members, and their families come to us in times of need, trusting that we will give them our very best medical care and service. We are committed to honoring their trust by providing excellent clinical care and superior service with the highest standards of integrity. This commitment applies to every aspect of our work, and is fundamental to our mission, vision, and values. At Intermountain Healthcare, we expect every employee, clinician, trustee, vendor, contractor, and volunteer who is part of our organization to understand and follow the rules and requirements that apply to their work.

General Ethics Standards

We are committed to Intermountain Health's values of Trust, Excellence, Accountability, and Mutual Respect as detailed in the online **Code of Conduct** booklet.

We perform our jobs and assignments with the highest standards of honesty and integrity. We treat each other, our patients and members, business partners, vendors and competitors fairly.

We know, abide by and understand the specific laws, policies and procedures that apply to our jobs and assignments, and to us as individuals.

We speak up with concerns about compliance and ethics issues. Specifically, we report observed and suspected violations of laws or policies, and we agree to report any requests to do things we believe may be violations. Furthermore, we cooperate with any investigation of potential violations.

We recognize that our daily work gives us each the opportunity to see problems in our local areas before they become apparent to others or to management. We are empowered and responsible to raise questions about potentially non-compliant or unethical practices.

If we have questions about a situation, we ask for help. We may talk to our supervisor or director, the facility/entity compliance coordinator, a company attorney, the Corporate Compliance Officer, or call the 24-hour Compliance Hotline at **800-442-4845**.

8.0 Coordination of Benefits (COB)

8.1 Definition

NOTE: With healthcare reform, dependents under the age of 26 may continue on their parents' policy regardless of residence, marital, or financial status.

Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including other health insurance, retiree benefits, auto insurance, workers compensation, etc.

8.2 Order of Benefit Determination

It is necessary to determine which policy has the primary responsibility to pay claims before other coverage is considered for benefit determination. The primary plan must provide its benefits as if the secondary or tertiary plans did not exist. A plan that does not include a COB provision may not take the benefits of another plan into account when determining benefits. The secondary plan may take the benefits of another plan into account only when the correct determination is made that the plan is in fact secondary. Since the order of benefits may differ for individuals within a family, each member must be reviewed individually.

Typical Order of Benefits

Each plan **(except those that include Medicare*)** determines its order of benefits using the first of the rules listed below that applies:

1. **Plans Covering Individual Other than Dependent (subscriber over dependent).** The plan that covers the person other than as a dependent (e.g., as an employee, member, subscriber, policyholder, or retiree) is the primary plan, and the plan that covers the person as a dependent is the secondary plan.
2. **Dependent Child, Parents not Separated or Divorced.** Order is determined as follows:
   - The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year.
   - If both parents have the same birthday, the benefits of the plan that covered the parent for the longer time period are determined before those of the other parent. Birthday refers only to the month and day, not the year in which the parents were born.
3. **Dependent Child (under 18), Parents Legally Separated or Divorced.** A copy of the decree is required. If the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or health insurance coverage, and the plan of that parent has actual knowledge of those terms, then that plan is primary. Dependents over 18 are no longer considered minors unless court documents indicate otherwise. Order is based on residency.

   If the parent with responsibility for health insurance has no coverage for the child's healthcare expenses, but that parent's spouse does, then the spouse's

* For members on Select Health Medicare plans (Advantage plans), review the information in Appendix A.

For traditional Medicare (not Select Health Medicare plans), order of benefit determination discussion begins on page 17.

plan is primary. If there is no court decree or it does not specify which parent is responsible for healthcare coverage, order is determined as follows:

a. The birthday rule of the parents
b. The longer/shorter rule of the policy holders

Joint Custody. If the court decree declares the parents have joint custody without stating which parent is responsible for healthcare expenses, follow the birthday rule.

Never Married or No Court Decree. If the parents are not married or are separated/divorced without a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows (as far as it applies):

a. The plan of the custodial parent

b. The plan of the spouse of the custodial parent

c. The plan of the non-custodial parent

d. The plan of the spouse of the non-custodial parent

4. **Active or Inactive Employee.** The benefits of a plan which covers a person as an employee who is active (neither laid off nor retired), or as that employee's dependent, are determined before those of a plan which covers that same person as an inactive (laid off or retired) employee, or as that employee's dependent.
5. **Consolidated Omnibus Budget Reconciliation Act (COBRA) Policy.** COBRA, mini-COBRA, or Continuation of Coverage (Conversion) plans are secondary to a plan covering the same person as an employee, member, subscriber, or retiree or covering the dependent of an employee, member, subscriber, or retiree. In other situations, follow normal determination of benefits rules. If the preceding rules cannot be used to determine the order of benefits, use the Longer/Shorter rule.
6. **Longer/Shorter Length of Coverage.** If none of the previous rules are applicable, the benefits of the plan that covered an employee or member longer are determined before those of a plan that covered the person for the shorter term.

   The employee or member's length of time covered under a plan is measured from their first date of coverage under that plan. If that date is not available, the date they first became a member of the group is used as the date to determine the length of time. Two plans are treated as one if the person was eligible under the second policy within 24 hours of the termination of the first policy. The start of a new plan does not include a change:

   a. In the amount or scope of a plan's benefits
   b. In the entity which pays, provides, or administers the plans' benefits
   c. From one type of plan to another, such as a change from small employer to a large group plan or from a single employer plan to a multiple employer plan

NOTE: If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

If the plans cannot agree on the order of benefits, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment.

NOTE: TRICARE dental uses standard coordination guidelines.

Always-Secondary Plans

Because of the government's role in subsidizing care for members enrolled in CHAMPUS/TRICARE and MEDICAID, these policies are always considered secondary to another plan.

Non-Complying Plans

A non-complying plan is one that does not use the outlined order of benefits determination. The rule of the non-complying plan determines the order of benefits. Select Health is a complying plan and coordinates benefits with non-complying plans according to the following:

- If Select Health is secondary to a non-complying plan, Select Health may provide benefits before the non-complying plan, but the amount of benefits payable does not exceed the amount Select Health would normally pay as the secondary payer. Select Health must request information from the non-complying plan about the benefits applied toward the claim.
- If the non-complying plan does not provide the information within a reasonable amount of time, the complying plan (Select Health) may process the claim as if the benefits of the non-complying plan were identical to those of Select Health. Once the actual benefits information is received, Select Health may adjust the amount paid based on the previous assumption.
- At no time should the complying plan (Select Health) pay more than Select Health would have paid had Select Health been considered the primary plan.

Federal Employee Health Benefits (FEHB) Plans Coordination Rules

- Dual coverage is not allowed with FEHB plan.
- Medicare is primary over FEHB annuitant (retiree).
- FEHB is primary over Medicare for an active employee's (or spouse of an active employee's) plan.

8.3 Traditional Medicare Order of Benefit Determination

Individuals who are age 65 or older may be eligible for Medicare. Certain individuals who are disabled, in end stage renal dialysis (ESRD), or kidney transplant patients may also be eligible for Medicare, regardless of age.

Medicare coverage has two parts:

1. **Hospital Insurance (Part A)** provides coverage of inpatient hospital services, skilled nursing facilities, home healthcare, and hospice care. Physician professional fees (e.g., anesthesiologist, radiologist, pathologist, etc.) are not covered under Medicare Part A, even when rendered in conjunction with a covered inpatient stay, etc.
2. **Medical Insurance (Part B)** provides coverage for physician services (including services rendered during an inpatient stay or other stay that is covered under Medicare Part A), outpatient services, medical equipment and supplies, and other health services and supplies.

Declined Medicare Part A, B, or Both

Some self-funded groups may apply sanctions if a member declines Medicare Part A, B, or both when they become eligible for age-related Medicare coverage. If a member age 65 or older is on a retiree policy with Select Health and obtains only Medicare Part A, Part B, or neither, Select Health will reduce the benefits by the amount Medicare would have paid (e.g., 80% of the billed amount or Select Health-eligible charges, whichever is less), where Medicare is prime for these groups.

Dependents

Where Medicare is prime for the subscriber, Select Health will continue to pay primary benefits on dependents (except spouse also eligible for Medicare) regardless of their eligibility for Medicare.

Medicare Special Circumstances

It is possible a member might elect Medicare Part B only. When this occurs, Medicare as a secondary payer (MSP), these guidelines do not apply. Medicare Part B is primary over an active policy.

Traditional Medicare coverage does not include prescription benefits unless the person also has part D and part C coverage. Select Health's prescription benefit applies for those who have Select Health Medicare.

Medicare does not pay for services rendered at a veteran's hospital (VA). The VA hospitals write off the amount Medicare would have paid, and Select Health coordinates benefits as usual.

Dual Entitlement

When a member is entitled to Medicare coverage for age or disability, and then becomes entitled to Medicare coverage for ESRD, Medicare eligibility and order of benefits determination for all services are as follows:

The 30-month coordination period only applies if Medicare was not the primary payer for the individual on the basis of age or disability at the time the individual becomes entitled to Medicare on the basis of ESRD.

1. If a member is entitled to Medicare based on age or disability, has group health plan coverage with an employer due to active employment, and then becomes entitled to Medicare based on ESRD, the guidelines for the ESRD 30-month coordination period will apply.
2. If a member is entitled to Medicare based on age or disability, has retiree coverage with a group health plan, and then becomes entitled to Medicare based on ESRD, Medicare remains primary. Prior to Medicare ESRD entitlement, Medicare was primary due to Medicare Secondary Payer rules. Becoming entitled to Medicare based on ESRD would not change the order of benefits.

Medicare Age 65+: Determining Order of Benefits

If the subscriber is over the age of 65, they are eligible for Medicare. Use the following guidelines to determine which policy is primary:

1. **Employer Groups with more than 20 employees:**
   - — Active policy (subscriber or dependent) is primary.
   - — Medicare policy is secondary.
   - — Inactive policy is tertiary.
2. **Employer Groups with less than 20 employees:**
   - — Medicare policy is primary.
   - — Active policy (subscriber or dependent) is secondary.
   - — Inactive policy is tertiary.
3. **Individual Policy — Medicare is primary.**

Disabled and Under 65: Determining Order of Benefits

Certain members who are disabled and under the age of 65 may be eligible for Medicare. Use the following guidelines to determine which policy is primary:

Number of employees refers to the total number of employees (full-time, part-time, or seasonal), not the number of employees eligible for benefits.

1. **Employer groups with more than 100 employees*:**
   - — Active policy (subscriber or dependent) is primary.
   - — Medicare policy is secondary.
   - — Inactive policy is tertiary.
2. **Employer groups with fewer than 100 employees*:**
   - — Medicare policy is primary.
   - — Active policy (subscriber or dependent) is secondary.
   - — Inactive policy is tertiary.
3. **Individual policy: Medicare is primary.**

End-Stage Renal Disease (ESRD): Determining Order of Benefits

Individuals who are receiving dialysis or renal transplantation for ESRD become eligible for Medicare protection starting the **third month** after the month the course of maintenance dialysis treatments began. This three-month qualification for Medicare period is known as the "waiting period." For example, if a member began a regular course of dialysis in July, they are eligible to select Medicare coverage beginning October 1. There are circumstances when Medicare protection can begin earlier, such as on the **first month** of dialysis, if:

- The member participates in a self-dialysis training program in a Medicare-approved training facility. The training must start before the third month after dialysis begins, and the member expects to complete the training and self-dialyze thereafter.
- Coverage can begin the month the member is admitted to an approved hospital for kidney transplantation or procedures preliminary to a transplant. The kidney transplant must take place within the two months following admission.

If the member becomes eligible for Medicare when the three-month ESRD waiting period has been satisfied, Medicare will be the secondary payer during a period of **30 months**, known as the "coordination period." The 30-month period during which Medicare may be secondary begins the first month the member is eligible for Medicare, whether or not the member enrolled. At the end of the 30-month coordination period, Medicare becomes the primary payer.

If the member has more than one period of Medicare eligibility due to renal failure, there is a separate coordination period for each occurrence. The waiting period does not need to be satisfied again. To illustrate, if a member received a kidney transplant that was successful for four years, then the kidney fails again necessitating dialysis or another transplant, Medicare coverage will be reinstated immediately without a waiting period.

When Medicare Protection Ends

NOTE: When a member is eligible for Medicare due to ESRD, Medicare will pay for all services normally reimbursed by Medicare, not just kidney related services.

If the member is eligible for Medicare only because of permanent kidney failure, Medicare coverage will end **12 months** after the month the member no longer requires dialysis or **36 months** after the month of a kidney transplant. Medicare Part B coverage can end at any time if the member fails to pay premiums or if the member decides to cancel.

If the member ends his/her Medicare coverage as a result of a return to good health, then has another episode of kidney failure, their Medicare eligibility is reinstated. If there is more than one period of Medicare eligibility due to renal failure, there is a separate coordination period for each occurrence. The waiting period does not need to be satisfied again. To illustrate, if a member received a kidney transplant that was successful for four years, then the kidney fails again necessitating dialysis or another transplant, Medicare coverage will be reinstated immediately without a waiting period.

9.0 Credentialing and Contracting Process

9.1 Credentialing

NOTE: You have the right to request information regarding the status of your application. You have the right to review your credentialing application, including any information obtained from any outside source, with the exception of references, recommendations, or other peer review-protected information.

We will notify you of any issues that may be identified, such as discrepancies or other issues with the information you provided, and you have the right to correct erroneous information. You will be notified of any problems in obtaining the required verifications.

For detailed information, access the:

- Credentialing Policies and Procedures Manual
- Select Health Credentialing Steps Checklist

Follow these steps to become a Select Health-contracted provider:

STEP 1: REVIEW OF THE PROVIDER PARTICIPATING REQUEST

Our team will review your Participating request to ensure all necessary information has been provided including your Council for Affordable Quality Healthcare (CAQH) number.

NOTE: If you don't have a CAQH Number, create a profile.

Select Health uses CAQH for credentialing and will work with you throughout the credentialing process for the Select Health networks.

If you do not have a CAQH number, register by:

1. Visiting the CAQH registration site at https://proview.caqh.org/pr/registration/selfregistration
2. Completing the CAQH provider registration
3. Receiving your CAQH ID number

STEP 2: REQUEST FILE FROM CAQH

Once the participation request is reviewed, Select Health will request your file to CAQH. This file includes a comprehensive application as well as Primary Source Verification documents needed for our credentialing review.

Be sure to review, update, and attest to all relevant data. As a reminder, information within CAQH needs to be current, including licenses and insurance documentation.

Watch for a notification from CAQH to enable Select Health permission to access your CAQH application in the "authorize" section of your application.

STEP 3: REVIEW OF CAQH FILE

Once we receive confirmation that your CAQH profile is updated and complete, we will download the data from CAQH and review the credentialing file for evaluation by the Select Health Credentialing Committee.

STEP 4: COMMITTEE REVIEW

Once all information has been collected and reviewed, your application will be reviewed by our credentialing committee. The committee evaluates your qualifications and determines your participation eligibility.

STEP 5: DECISION AND NOTIFICATION

After the committee's review, you will receive a notification regarding the outcome of your credentialing application. If approved, you will be informed of next steps including signing a contract (if required)

9.2 Contracting

Once credentialing is complete, you will receive a contract (via Adobe PDF) entitled, "**Select Health Participating Practitioner Service Agreement (PPSA),**" or a "**Select Health Participating Facility Agreement**" for facilities and vendors. The networks included in the PPSA will be based on those networks offered in each state, such as:

- **Utah**: Select Health Choice, Select Health Care, Select Health Med, Select Health Value, Select Health Share, Select Health Signature, and Select Health Medicare
- **Colorado**: Individual ACA plans, Select Health Value, and Select Health Medicare
- **Idaho**: Select Health Med and Select Health Medicare
- **Nevada**: Select Health Med, Select Health Value, and Select Health Medicare

Sign the contract according to the instructions in the email.

You will then receive your executed contract, and the date of the executed contract will be your actual effective date with Select Health.

10.0 Fraud/Waste/Abuse (FWA) Program

The Select Health Special Investigations Unit (SIU) has the primary responsibility of investigating fraud and abuse for Select Health. The SIU works very closely with the State of Utah:

- **Insurance Fraud Division** in sharing issues of concern, referring insurance fraud and abuse cases for investigation, and in complying with the State of Utah mandatory reporting requirements for fraud
- **Department of Professional Licensing (DOPL)** in reviewing issues that pertain to providers and members, including the investigation of potential fraud and abuse cases

Audits and reviews of provider claims include, but are not limited to, appropriate coding procedures, appropriate supporting documentation for claims, and any ordered tests or other procedures, retention of medical records and supporting documentation, excessive charges, documented benefits and exclusions, preauthorization requirements, timeliness of claims submissions, panel vs. non-panel status and reimbursements, member eligibility, and any other appropriate reviews.

10.1 FWA Oversight and Protection Program

All referrals to the SIU are reviewed and investigated where appropriate, and subsequently, all pertinent referrals are provided to the SIU Steering Committee, which then makes a determination as to whether or not the information needs to be reported to the State Insurance Fraud Division, under the guidelines of the State Mandatory Reporting laws.

The Steering Committee is composed of representatives from Executive Management and from various departments throughout Select Health who have been given the mandate of ensuring that Select Health is in compliance with the State Mandatory Reporting Act and with Select Health's own policies and procedures.

This committee oversees the fraud and abuse efforts of Select Health and ensures those efforts are appropriate and within established guidelines and applicable laws.

10.2 Mandatory Reporting of Fraud or Abuse

Select Health has an established policy for reporting insurance fraud to the State Insurance Fraud Division, as required by the state mandatory reporting law. This policy requires all Select Health employees to report to their immediate supervisor, the Select Health Compliance Department, or the Select Health SIU, any situations wherein the employee has a good faith belief that a fraudulent insurance act is being, will be, or has been committed. This good faith belief may also include situations that appear to be acts of insurance abuse, which will also be considered by the SIU.

All referrals to the SIU are investigated, and subsequently, all pertinent referrals are provided to the SIU Steering Committee, which will then make a determination as to whether or not the information needs to be reported to the State Insurance Fraud Division.

10.3 FWA Training and Attestation

The Centers for Medicare & Medicaid Services (CMS) require that all healthcare professionals who provide services to Medicare beneficiaries complete some type of annual training program on FWA within 90 days of employment/contracting and annually thereafter.

You and each of your employees are required to complete the training and submit an attestation of completion annually that addresses compliance requirements, including:

- Distribution of Standards of Conduct and maintaining record of that distribution
- Completion of FWA and General Compliance training and maintaining record of the completion of that training
- The availability of a system to receive reports (reporting mechanism) of suspected noncompliance and/or FWA that is confidential, allows anonymity, and includes a policy of non-intimidation and non-retaliation
- Federal exclusion list screening and maintaining record of timely checks against those lists
- Monitoring and auditing downstream entities
- Identification of use of offshore subcontractors
- Record retention for 10 years

NOTE:
You can find additional resources in the **Select Health Medicare area** of the provider website.

11.0 Healthy Beginnings

For additional information, call Healthy Beginnings at **801-442-5052** or email **commhealthybeginnings@selecthealth.org**.

Select Health Healthy Beginnings is a program created for expectant members. It is available at no additional cost to the member and is designed to work with the provider to promote a healthy pregnancy.

Enrolling in Healthy Beginnings provides members with:

- Access to a high-risk perinatal nurse care manager
- Mental Health screenings and referral to behavioral health providers as needed
- Assistance in answering questions, offering emotional support, and providing referrals to community resources, such as Women, Infants and Children (WIC)
- Educational materials on pregnancy, childbirth, breastfeeding, and newborn care
- Information on pre-term labor signs and symptoms with instructions to contact provider or go to nearest hospital labor and delivery department
- Financial incentives that may be available after completing first prenatal and postnatal visits*
- Guidance on how to obtain a breast pump

Connecting members with the Healthy Beginnings program can be done by:

1. Making the Healthy Beginnings flier/rack cards available in the provider's office
2. Calling **801-442-5052**
3. **Using the QR code (at left)** to complete a referral
4. Sending member demographic information via:
   - Email: **commhealthybeginnings@selecthealth.org**
   - Fax: **801-442-0825**

NOTE: **Download flyers** in English and Spanish, or call **801-442-5052** to order printed rack cards for public areas of your clinic.

(Use QR code for step 3 at right.)

* Depending on member's plan, financial incentives may be available after a prenatal visit before the end of the 13th week of pregnancy or a postnatal visit within 50 days of birth. Incentives received may be considered income and subject to tax.

12.0 Medical Necessity

* For members on Select Health Medicare plans (Advantage plans), review the information in **Appendix A**.

NOTE: Medicaid does not reimburse providers for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products, or devices that are considered experimental, investigational, or unproven.

Medical necessity provides the most appropriate supply or level of service known to be effective and takes into consideration potential benefits and harms to the patient.

Healthcare services, equipment, care, and supplies must be medically necessary to be covered. However, only services that are covered by Select Health will be eligible for reimbursement.

It is the responsibility of the provider to determine medical necessity. However, the fact that a provider, even a participating provider may prescribe, order, recommend, or approve healthcare services, equipment, care, or supplies does not necessarily make it medically necessary, even if it is not listed as an exclusion or limitation.

12.1 Definition of Medical Necessity/ Medically Necessary

The standard definition of "Medical Necessity/Medically Necessary" is the **same for all commercial plans in Colorado, Idaho, Nevada, and Utah** and reads as follows:

"Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice in the United States
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the convenience of the patient, physician, or other provider"

12.2 Determining Medical Necessity

When a medical question of fact exists, medical necessity shall include the most appropriate available supply or level of service for the member in question, considering potential benefit and harm to the member.

Medical necessity is determined by the treating physician and by Select Health's Medical Director or designee. The fact that a provider or facility, even an in-network provider or facility, may prescribe, order, recommend, or approve a service does not make it medically necessary, even if it is not listed as an exclusion or limitation. Neither does FDA approval or other regulatory approval establish medical necessity.

Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality.

For interventions not yet in widespread use, the effectiveness is based on a medical practice that:

- Has been proven to be as effective or superior to conventional therapies
- Is widely utilized as a standard medical practice for specific conditions
- Has been approved as a covered Medicaid service by division staff and physician consultants on the basis of "medical necessity"

Questions? Contact Member Services at:

- **801-442-5038** (Salt Lake area) or **1-800-222-6358** for Commercial Plans
- **855-442-9900** for Select Health Medicare (Medicare)
- **800-538-4234** for Select Health Community Care® (Medicaid)

13.0 Member Advocates

Provider offices can reach the Member Advocates by calling either:

- **801-442-4993**
  (Salt Lake area)
- **800-515-2220**

Select Health Member Advocates℠ are a valuable resource for providers who want to help patients access the best care possible and build their practice. Member Advocates are trained to assist members by helping them understand and follow plan guidelines, find appropriate providers, and become empowered to make informed healthcare decisions.

This service benefits provider offices in the following ways:

- Providing valuable and accurate information about you and your practice to members who are seeking a healthcare provider or specialist.
  We use information we receive from providers and their office staff, so we can periodically check to make certain we have your most current information.
- Helping patients access secondary or ancillary providers based on your recommendations.
- Helping patients access offsite labs and diagnostic testing facilities covered by their health plan.
- Providing assistance for building healthcare practices by letting members know they are accepting new patients.

Member Advocates help patients by:

- Locating a primary care or specialty care provider who is accepting new patients
- Identifying physicians who speak a foreign language
- Scheduling an appointment with a provider
- Getting an appointment for urgent care when their PCP is unavailable
- Obtaining information about providers, such as where they went to medical school, completed their residency, or their board status
- Setting up appointments for annual exams, immunizations, and checkups
- Increasing patient confidence by setting expectations and making them aware of the provider's expertise in advance of their first appointment
- Completing a nonparticipating physician review, ensuring the right care is provided by the right physician at the right time

14.0 Member Appeals

* For members on Select Health Medicare plans (Advantage plans), review the information in **Appendix A**.

Most member issues can be resolved informally through Member Services by calling **800-538-5038**. If a member is not satisfied after attempting to resolve the problem with Member Services, they may choose to:

1. Initiate an appeal (by submitting an **Appeal Form**)
2. Authorize someone else (such as a provider) to do so on their behalf

NOTE: A written authorization is required if a member wants to designate **anyone other than a provider** (e.g., a spouse, family member, or an attorney).

A member can designate their provider to represent them through the appeals process without having to provide a written authorization to do so. With enrollee consent, providers can file an appeal of any adverse benefit determination on behalf of the enrollee by completing and submitting **the online appeal form** or via the **Provider Benefit Tool** (secure login required).

An adverse benefit determination is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

Filing requirements for making an appeal differ based on the type of plan as follows:

- **For Commercial plans**: Formal appeals must be filed within **180 days** from the date of denial notification.
- **For Government plans**:
  - **Select Health Medicare (Medicare) plans**: Appeals must be filed within **60 days** of the Adverse Benefit Determination.

    Contract provider disputes involving plan payment denials are reviewed through the Provider Appeal dispute resolution process between the provider and the plan (see Section 20.0 on **page 35**).
  - **Select Health Community Care (Medicaid) plans**: Appeals must be filed within **60 days** of the Adverse Benefit Determination.
  - **CHIP**: Appeals must be filed within **60 days** of the Adverse Benefit Determination.
  - **Federal Employee Health Benefits program**: Appeals must be filed within **180 days** from the date of denial notification.

NOTE: For Medicare, contract providers do not have appeal rights under the member appeals process.

You will receive a written acknowledgment upon receipt of the appeal.

You may request an expedited review of an adverse benefit determination if the normal time frames for a determination **either**:

- Could seriously jeopardize the enrollee's life, health, or ability to regain maximum function; **or**
- Would subject the enrollee to severe pain that could not be adequately managed without the requested service.

If the expedited appeal is denied, the appeal will be managed according to the standard time frame. If you do not agree with the result of the appeal, you will be notified of any further appeal rights.

Medicaid/CHIP-Required Content of Notice of Adverse Benefit Determination: All written Notices of Adverse Benefit Determination required by this Contract shall explain that the time frame for filing an oral or written appeal request, which is within 60 calendar days from the date on the Contractor's Notice of Adverse Benefit Determination **(see standard appeal process information for Medicaid and CHIP on page 67).**

15.0 Member Notification Upon Provider Termination from Select Health

The following statement is included to each Participating Provider Services Agreement (PPSA) signature page for Select Health participating providers. It is also included in this manual as notice of this policy to all current Select Health participating providers.

"I agree that if I terminate this agreement, I will give at least 60 days written notice prior to the termination. Upon written notification of termination, Select Health will notify, at least 15 calendar days prior to the effective date of termination, the Select Health members who have received care in my practice that I will no longer be a participating provider with Select Health. I understand that Select Health will assist the member in making arrangements for future medical care."

16.0 Pharmacy Tools

Select Health Pharmacy Provider Reference Manual

For detailed information regarding Select Health Pharmacy guidelines, please see the **Select Health Pharmacy Provider Reference Manual**.

Additional Pharmacy Tools

Access additional pharmacy information, including:

- **Pharmacy/Coverage Search:**
  - **https://www.selecthealth.org/pharmacy/resources** (Select "Find Pharmacies.")
  - **https://www.selecthealth.org/pharmacy/resources/pharmacy-coverage**
- **Prescription Drug Lists/Formularies/Drugs with Special Requirements:**
  - **For Commercial Plans: https://selecthealth.org/providers/programs/pharmacy/lists-and-formularies**
  - **For Medicare Plans: https://selecthealth.org/providers/programs/pharmacy/medicare-tools**
  - **For Medicaid Plans: https://selecthealth.org/content/dam/selecthealth/Medicaid/PDFs/traditional-pdl-druglist.pdf**
- **Intermountain Home Delivery:** **https://intermountainhealthcare.org/services/pharmacy/home-delivery/**
- **Medication Therapy Management (MTM) Program (Select Health Medicare):** **https://selecthealth.org/medicare/pharmacy/resources/medication-therapy-management**
- **Opioid Prescribing Resources:** **https://selecthealth.org/providers/programs/pharmacy/opioid-prescribing**

Pharmacy updates also appear in the *Provider News Digest* online newsletter. **Get the latest news.**

17.0 Pre-Existing Conditions (PECs)

17.1 PEC Definitions

NOTE: Select Health currently offers transition plans in Utah and Idaho and only enhanced short-term plans in Idaho. There are no short-term policies in Nevada or Colorado.

A PEC is defined based on the applicable state transition plan (STP) or enhanced short-term plan.

UTAH Transition Definition

A condition or symptom is considered "pre-existing" if **either** criteria exists:

1. The condition or symptom would cause an ordinarily prudent person to seek diagnosis, care, or treatment, and it occurs within the two-year period preceding the effective date of coverage; **OR**
2. The condition or symptom occurred in the one-year period preceding the effective date of coverage for which medical advice, care, or treatment was received from or recommended by a provider, including but not limited to prescription and over-the-counter medication recommended by a provider.

IDAHO Transition Definition

A condition or symptom is considered "pre-existing" if:

1. An eligible individual's condition for which medical advice, diagnosis, care, or treatment (including prescription and over-the-counter medication recommended by a provider) was either received from or recommended by a provider during the **six-month** period prior to the effective date.
2. During the six-month period immediately preceding the effective date of the contract, symptoms existed that would cause a prudent person to seek medical diagnosis, advice, care, or treatment.

IDAHO Enhanced Short-term Plan Transition Definition

A condition is considered "pre-existing" if:

1. An eligible individual's condition for which medical advice, diagnosis, care, or treatment (including prescription and over-the-counter medication recommended by a provider) was either received from or recommended by a provider during the **six-month period** prior to the effective date.
2. During the six-month period immediately preceding the effective date of the contract, symptoms existed that would cause a prudent person to seek medical diagnosis, advice, care, or treatment.
3. There is a pregnancy that existed on the effective date of coverage.

17.2 PEC Waiting Periods and Exclusions

The PEC waiting period for transition plans is not waived, even if the member had prior coverage; however, the STPs and enhanced short-term plans may be considered creditable coverage.

Elimination of PEC Waiting Periods and Exclusions: The Affordable Care Act (ACA) mandates insurers/employer groups may not impose PEC waiting periods or exclusions on ACA plans.

Plans Not Subject to the Elimination Provision of the ACA: The period may be waived if proof of prior coverage is obtained.

Creditable Coverage Certificate (CCC)

What is a CCC?
Insurance carriers provide certificates to their members as proof of prior insurance coverage whenever a plan is terminated.

The Health Insurance Portability and Accountability Act (HIPAA) regulations no longer require insurance carriers to send a **certificate of creditable coverage (CCC)**; however, Select Health sends a verification of coverage letter to members upon plan's termination. This automatically generated letter includes the dates the member's coverage with Select Health began and ended.

Members may need these CCC letters if they want to enroll in a new plan through a special enrollment.

18.0 Preauthorization

* For members on Select Health Medicare plans (Advantage plans), review the information in **Appendix A**.

Select Health requires submittal of preauthorization forms or requests via our online preauthorization tools:

- The **Preauth & Care Plan Tool**, which offers more efficient and sometimes auto-approval of preauthorization requests
- **PromptPA**, which facilitates online preauthorization for medications and other products requiring authorization from our pharmacy department for our members

Procedures and services requiring preauthorization are listed in the online preauthorization lists for Commercial products, Select Health Medicare, and Select Health Community Care.

Access **preauthorization forms and tools** as well as **PromptPA** from the Select Health provider website.

Access current preauthorization forms to download and submit **if not using one of the above-mentioned online tools**. When submitting these forms, ensure adequate time for a preauthorization whenever reasonably possible by notifying Select Health at least 14 days in advance of services.

It is the responsibility of Select Health to determine whether healthcare services are a covered benefit. Examples of services that are non-covered benefits are procedures, equipment, and/or medications that are cosmetic, investigational, or experimental in nature. Select Health may use medical criteria sets and/or physician review to determine whether a procedure is cosmetic, investigational, experimental, or an otherwise non-covered benefit. If a provider's office has questions about a covered benefit, they are encouraged to use the preauthorization process, whether the procedure is on the preauthorization list. Using the preauthorization process to verify benefit coverage can be an important tool in understanding reimbursement.

Questions? Call Member Services at **801-442-5038** (Salt Lake area) or **1-800-222-6358**.

18.1 Member Responsibility

If the member is using a non-panel facility, preauthorization is a member responsibility. Failure to preauthorize a service may result in standard benefits being reduced up to 50 percent of eligible charges, and member payments are not applied to the member's out-of-pocket maximum.

Members on a plan with a point-of-service feature (Select Health Choice®, Select Health Med Plus®, and Select Health Care Plus®) are responsible to complete preauthorization for certain services from non-participating providers.

18.2 Information Needed

The following information is **required for preauthorization**:

- Subscriber number
- Provider of service
- Facility
- Diagnosis code(s)
- Date of service
- Place of service
- Procedure code(s)

You may request an expedited review **ONLY IF** the standard time frame for your state could result in:

- Seriously jeopardizing the life or health of the member
- Seriously threatening the member's ability to regain maximum function
- Delaying the care and treatment of this request would subject the member to severe pain and inadequate management of the member's medical condition

Preauthorization is not a guarantee of payment. Reimbursement of preauthorized services is contingent upon eligibility and benefits at the time of service and services that are covered benefits.

18.3 Additional Contact Information

For questions regarding pharmaceutical preauthorization requirements, call the Select Health Pharmacy Help Desk at **801-442-4912** (for the Salt Lake area) or **800-442-3129**.

Providers requesting a peer-to-peer discussion on a benefit determination, including preauthorzation and concurrent review, may call **801-442-5305**.

Select Health Medical Criteria Sets are outlined in each **medical policy**. Criteria are also available upon request by calling **800-442-5305**. Please specify if you would like to receive the criteria via mail, fax, or email.

Health Services staff are available to discuss utilization management (UM) issues from 8:00 a.m. to 5:00 p.m., Monday through Friday. After normal business hours, fax UM questions to **801-442-0517**.

19.0 Preventive Care* Recommendations

* For members on Select Health Medicare plans (Advantage plans), review the information in **Appendix A**.

Coverage of preventive services on Select Health Community Care (SHCC) patients will follow the coverage guidelines for Utah Medicaid.

Select Health uses preventive care recommendations from national sources (e.g., the **US Preventive Services Task Force** or the **Centers for Disease Control and Prevention)** with input from Intermountain Health to help providers improve preventive care services. This is accomplished through standardizing national recommendations, connecting provider resources, and developing clinical tools for managing preventive processes.

Recommendations cover the routine care of adults as well as adolescents and children and do not include signs and symptoms. Due to the variations inherent to a medical practice, not all issues are covered. An individual's specific risk factors and environment should be considered when prioritizing issues to address.

While preventive care is a partnership between the patient and their provider and the healthcare system, the patient is primarily responsible for their behaviors and creating an environment that is conducive to health. Patients should be encouraged to disclose lifestyle issues or habits that may affect preventive care.

20.0 Provider Appeals

20.1 Filing a Formal Appeal

The Select Health Provider Appeals process addresses disputes that arise between a healthcare provider and Select Health. Examples of provider appeals include issues regarding modifiers, multiple surgeries. This process does not apply to appeals dealing with credentialing decisions, contract terminations, member appeals initiated by a provider, or fee schedule issues. If you have questions about any of these issues, contact your Select Health Provider Relations representative.

Appeals can be filed online using the **Provider Benefit Tool (PBT)**, which requires a secure login to access member information (**learn more about gaining access and user training**). For those who do not have access to the PBT, follow these steps to file a formal appeal:

1. Access the **Provider Appeal form**.
2. Complete the online fillable form, and save it to your computer/device .
3. Upload the completed form and medical records on the **Provider Benefit Tool** or mail/email the documents to Select Health within **180 days** (for Commercial and Medicare) or **90 days** (for Medicaid) from the date the claim was processed to:

   Select Health Provider Appeals
   P.O. Box 30192
   Salt Lake City, UT 84130-0192
   Email: **shawdprovider@selecthealth.org**
4. You will receive a written acknowledgment via mail upon receipt of the appeal.

20.2 Understanding the Review Process

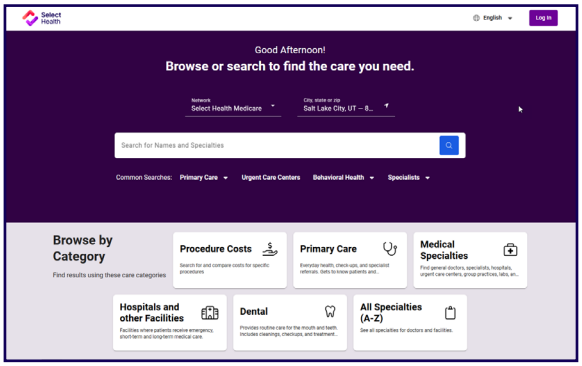
Only submit a provider appeal once to Select Health; it will be routed to the appropriate individual/department for a determination.

You will receive a written response **within 60 days** of receipt of the appeal, indicating the review result.

If you do not agree with the result, contact your Provider Relations representative.

21.0 Provider Directory

Select Health maintains an online provider directory (also available as a print version that can be sent to a member upon request). The directory allows the member to determine what providers take new patients, their demographics, and specific aspects of their practice (e.g., ADA accommodations).



Although directory compliance requirements may differ from time to time and among one network to another, they center on ensuring information accuracy via attestations, such as:

- **Provider Demographic Information Attestation**: Per the Centers for Medicare and Medicaid Services (CMS) and the Consolidated Appropriations Act, practitioners are required quarterly to attest and update their demographic information. Select Health provides for these attestations via a quarterly Qualtrics survey sent to the provider's email inbox.
- **Offer their services via Telehealth:** Effective **July 1, 2025**, if a provider offers telehealth services, it will be indicated in the provider directory (in compliance with the Consolidated Appropriations Act [CAA], which requires indicating those Medicaid/CHIP providers offering covered services via telehealth).
- **Equal Access for Those with Disabilities:** When updating information in the quarterly demographic attestation, please update the specific ADA accommodations offered for those with disabilities along with clinic location to specify whether each location meets the ADA standards. Per CMS (42 CFR 438.206a), the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act, these standards require healthcare providers to provide individuals with disabilities full and equal access to their healthcare services and facilities.
- **Fraud/Waste/Abuse (FWA) Training Attestations**
  Per CMS Medicare Managed Care Manual, Ch. 21 (50.3.2), practitioners who see patients on Medicare are required to:
  - — Participate in FWA training
  - — Attest that compliant training has been completed in the first 90 days of contract/hire date and annually thereafter

  NOTE: Using the previously required, CMS-issued content is no longer mandatory; however, this training is still available as an option.

NOTE: Compliance requirements provided in this section are **examples** rather than a comprehensive list. Requirements can also change from time to time.

For questions about the latest requirements, contact your Provider Relations representative.

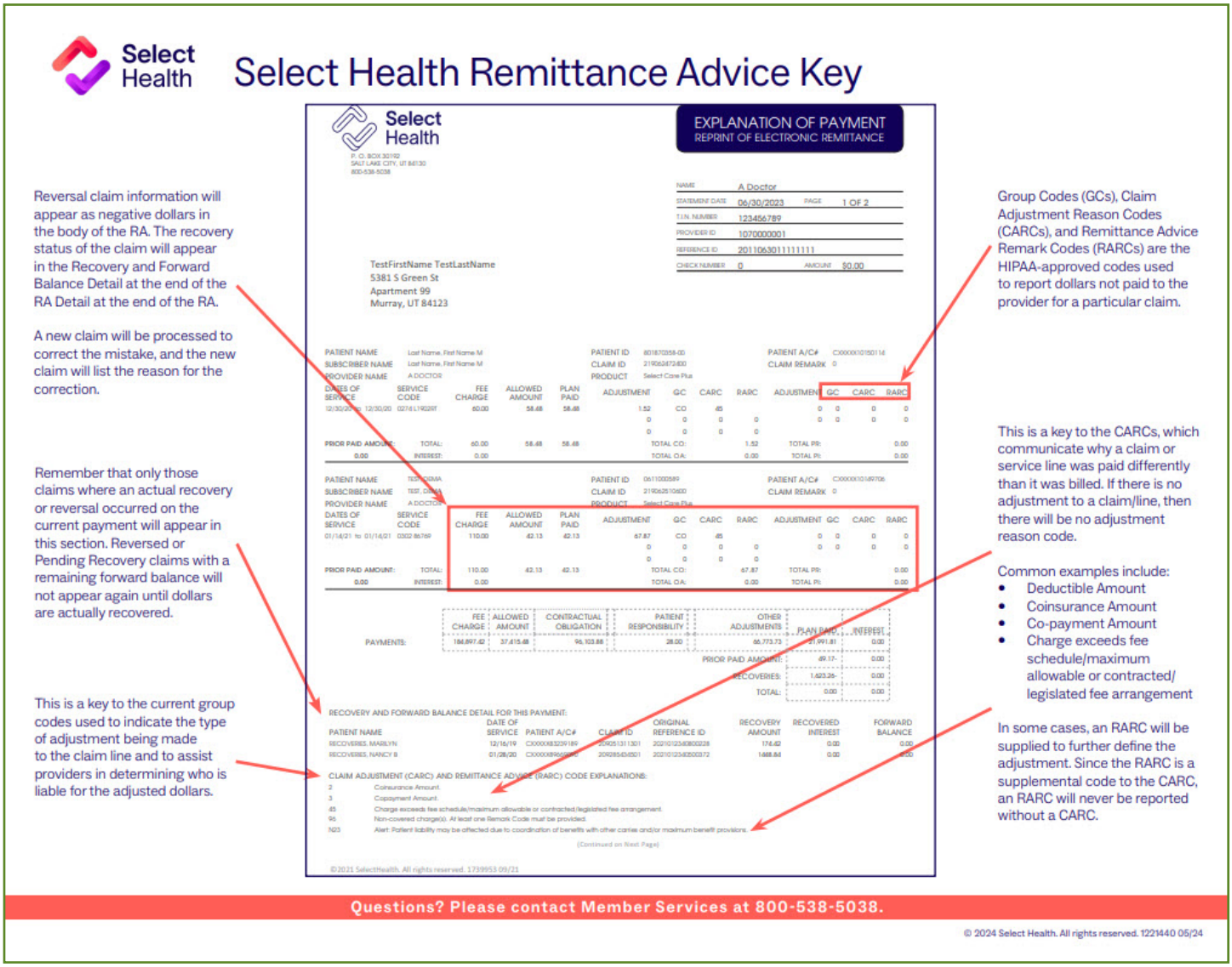
22.0 Provider Remittance Advice

The Utah Health Information Network (UHIN) has requested all payers report Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and associated Group Codes (GC) for each claim billed.

The CARCs and RARCs allow providers to more easily bill eCOB for secondary claims.

Figure 1 below is a copy of our remittance advice key; you can also access the full-size **Remittance Advice Key** online.

Figure 1. Remittance Advice Key



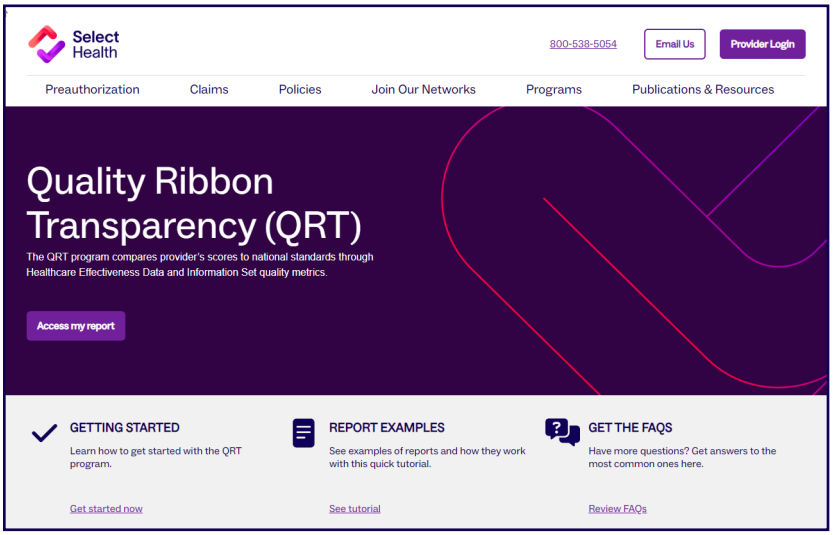
23.0 Public Reporting

Select Health publicly reports clinical quality and patient satisfaction data. Providers should contact the Intermountain Clinical Excellence Department for details regarding their patient experience data (see 22.2 below). Providers' clinical quality data is available to view on the Select Health provider search page or a more detailed report is available through the **Quality Ribbon Transparency Program**.

23.1 Clinical Quality Data

The Select Health Quality Ribbon Transparency (QRT) program publishes provider scores in comparison to national standards through Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics. Designed for public transparency about how Select Health-contracted providers perform on HEDIS metrics, the QRT:

- Improves the trust members have with the providers they choose
- Fosters better outcomes and patient satisfaction
- Promotes clinical quality improvement among healthcare providers by comparing their rates to their peers



Access online information for getting started with this program, a tutorial with examples of reports, and answers to common frequently asked questions.

23.2 Patient Experience Data

Patient experience depends on strategies and processes that improve the patient's perceptions of their care, safety, and equity. The Intermountain Health Clinical Excellence Department maintains an online toolkit for providers.

To learn more:

- Access the **Patient Experience Toolkit** (secure login required).
- For more information, contact **Nathan.Hoffmann@selecthealth.org**

24.0 Quality Assurance and Operation Standards

24.1 Requirements

General quality assurance and operation requirements are that the **provider agrees to**:

1. Comply with the Select Health Quality Assurance Program in all respects, including, but not limited to participating in the Select Health member grievance and appeal processes and procedures.
2. Comply with the Select Health Utilization Management Program, including, but not limited to providing prenotification or precertification, when required by Select Health, as will be required for all non-emergency services.
3. Ensure that, except for emergency situations, services to members should be provided by those entities that have contracted with Select Health to provide such services to members.
4. Cooperate with credentialing process undertaken by Select Health and to cooperate with plans in meeting National Committee for Quality Assurance (NCQA) accreditation requirements.

Upon request, **Select Health agrees to** give to provider copies of all quality assurance, utilization management and operational standards and requirements (and of any changes to such standards and requirements) that the provider must comply with, pursuant to this agreement.

24.2 Record-keeping Requirements

Specific for Provider and Plan Requirements

All medical records will be maintained to comply with applicable state and federal laws dealing with the privacy and confidentiality of medical records. **Provider agrees to maintain**:

1. All financial and medical records required by law or industry practice for all services rendered to members and to permit a representative of Select Health to examine and audit such records upon reasonable advance request.
2. These records for a period of five years after rendering services and make such records available for review by Select Health and by state and federal authorities and their agents for purposes of:
   - Assessing medical necessity and the quality and appropriateness of care
   - Investigating member grievances and complaints

Provider also agrees to furnish to Select Health, without charge, copies of all records reasonably needed to substantiate claims for payment for facility services.

Select Health agrees to:

1. Keep appropriate administrative and claims files and records
2. Upon request, give the provider utilization, quality-assessment, and other available records and reports.

Medical Records Audit Standards

Select Health monitors the consistency and completeness of medical record documentation as part of an effort to ensure quality patient care. The Select Health goal is 100% provider compliance with the Provider Office Medical Record Standards used to evaluate medical records in **Figure 2** (below and the next page).

Figure 2. Provider Office Medical Record Standards

Topic	Medical Record Standards
Allergy and/or Adverse Drug Reactions	Medication allergies/adverse reactions should be prominently noted (in an easily recognizable location) on the record. Electronic Medical Record (EMR) computer screen notes and/or EMR hard-copy notes may be used as the prominent location for medication allergies/adverse reactions. The absence of allergies and adverse reaction to medications should also be noted in an easily recognizable location (e.g., NKA - No Known Allergies or NKDA - No Known Drug Allergies).
Appropriate Use of Consultants	Consultations used should be consistent with the chief complaint and diagnosis.
Availability	All medical records should be readily available to health providers at each encounter upon request.
Biographical/Personal Data on Patient	Personal/biographical data should include address, employer, home and work telephone numbers, and marital status.
Chart Format	All records, reports, consultations, summaries, etc. will be secured within the record/folder. There should be records for only one patient in each file. In a family chart, each patient should have his or her own file within the chart. The types of forms used in the medical record and the order in which the forms are placed in the medical record shall be consistent from record-to-record within each practice site.
Confidentiality	All medical records should comply with the provider office confidentiality policy and in accordance with the Select Health Participating Provider Service Agreement and applicable laws and regulations, such as HIPAA. Providers shall have a policy and/or procedure regarding the release of patient information. The provider shall afford patients the opportunity to approve or refuse the release of identifiable personal information or organization, except when required by law.
Consultants, Labs, and Imaging Reports Initialed by Provider	Consultation, labs, and imaging reports filed in the chart should have the provider initials to signify review. If the reports are presented electronically or by some other method, there is also representation of ordering provider review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.
Continuity of Care	If a consult is requested, a note/letter from the consultant should be included in the record.

Figure 2. Provider Office Medical Record Standards, Continued

Topic	Medical Record Standards
Entries Dated	Each entry should have a date indicating the date of the visit.
History and Physical	The history and physical exam records appropriate subjective and objective information pertinent to the patient presenting complaints.
Immunization Records	For children age 13 and younger, the medical records should contain the date for all immunizations given. For children older than age 13, a notation that "immunizations are up-to-date" will meet the guidelines. For adults age 19 and older, an appropriate history should be made in the medical record.
Labs and other Studies Ordered as Appropriate	Labs and other studies ordered should be ordered as appropriate.
Legible to Reviewer	The record should be legible to someone other than the writer.
Pages Contain Patient ID	Each page in the record should contain patient name or patient ID number.
Past Medical History	Past medical history (for patients seen three or more times) is easily identified including serious accidents, operations, and illnesses. For children and adolescents (age 18 and younger), past medical history will relate to prenatal care, birth, operations, and childhood illnesses.
Plan of Action/Treatment Consistent with Diagnosis	The treatment plan described in the medical record should be consistent with the diagnosis.
Preventive Services	There should be some indication that preventive screening and services are being offered in accordance with Select Health preventive care practice guidelines.
Problem List	Significant illnesses and medical conditions should be indicated on the problem list.
Problems from Previous Visits Addressed	Unresolved problems from previous visits should be addressed in subsequent visits.
Provider Identified on Each Entry	All entries in the medical record should contain author identification. (If the provider is in a solo practice, signing of office notes is optional.) Author identification may be handwritten, stamped, or electronic. Dictated notes do not require initialing.
Return Visit or Other Follow-up	Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. For a healthy patient, a provider may indicate follow-up on a "PRN" (as needed) basis.
Smoking/Alcohol/Substance Abuse	For patients age 12 and older, there should be appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history). If the patient declines responding, a note indicating this should be present.

24.3 Office Site Visits

An office site visit will be conducted by a Select Health Provider Relations representative, if necessary for a member complaint or concern. Actions will be instituted to improve offices that do not meet standards and evaluate effectiveness of actions at least every six months until deficit is resolved. Member complaints will be continually monitored, and a site visit will be performed within 60 days of the complaint. Follow-up visits for offices that had subsequent deficiencies will be documented.

In addition, if a provider notifies Select Health that they are moving to a new location and/or are adding an additional location(s), Provider Relations will explain the process and will schedule an office site visit at the new and/or additional location(s) if an office site visit has not ever been conducted at the new location. The site visit must be completed prior to the new location(s) being added to the Select Health data systems, as applicable.

Required and Recommended Standards for a Favorable Rating

Listed in **Figure 3** below are required standards for patient Education and rights as well as medial records. **Figure 4** on the next page, provides those standards for which there are both required and recommended standards.

Figure 3. Required Quality Indicators

Quality Indicators: All Standards Required	
Patient Education & Patient Rights	Patient educational programs, pamphlets, or booklets for common medical issues relevant to the practice type (e.g., pregnancy & childbirth, diabetes, hypertension, weight loss, smoking cessation, etc.)
	Demonstrated concern for patient privacy (e.g., protecting disrobed patients from public view, using gowns and/or drapes to cover patients during examinations, closing doors during patient visit)
	Procedures regarding confidentiality and release of information
	Knowledge of reportable communicable diseases and health conditions as outlined by the Utah Department of Health
Medical Records	Availability of a sample record*
	Medical records that adhere to all Select Health medical records policy aspects, as applicable (e.g., secure/confidential filing system, legible markers, records easily located)

* Confidentiality regulations prohibit a provider from showing a medical record that belongs to a patient who is not a member of Select Health. As a result, the reviewer may request to see a sample record. A sample record is one that has been established, usually for office personnel, which demonstrates how a record should be assembled for a new patient. It will not contain a patient identifier or clinical information. Once the provider becomes a participating provider, medical records may be reviewed as part of the review process to assure that the provider is keeping records that meet at least the minimal medical record quality indicators.

Figure 4. Required and Recommended Quality Indicators

	Quality Indicators	
	Required	**Recommended**
Accessibility & Appearance	Ability to accommodate the disabled in compliance with state and federal standards (e.g., Americans with Disabilities Act [ADA], handicapped parking, and access) Clean, well-lit, office that provides adequate seating for patients to feel comfortable receiving care	A reception area that permits a receptionist to observe the waiting room Adequate parking to handle the expected patient volume
Safety	Fire extinguisher(s) that is (are) routinely checked by recognized agency according to local ordinances Building that meets local fire/safety code for smoke alarms	Visible exit signs, evacuation plan, and posted evacuation routes Clear and unobstructed passageways
Provider Availability	24-hour service for emergent and/or urgent situations for all members* A method to schedule emergency and urgent visits within the routine office schedule for minimizing unexpectedly long waiting times for previously scheduled patients	Methods to: Monitor and compare the number of patients served per hour versus scheduled per hour. Schedule extra time for visits that take longer than routine visits (e.g., physical examination, a patient with complicated health issues, special procedures).
Emergency Preparedness	Office staff trained in CPR, available during business hours, and able to verbally describe what to do when a patient suffers a life-threatening emergency while in the office (e.g., heart attack) Posted emergency telephone numbers (e.g., for ambulance, hospital, poison control, and/or 911)	Emergency resuscitation cart present: Maintain procedures for routinely checking the cart for pharmaceutical and sterilized equipment expiration dates and nonfunctional equipment (e.g., dead batteries in the laryngoscope). Defibrillator present: Office staff provides education and training on proper equipment maintenance and operation.
Medications	Storage safeguards for needles and syringes as well as over-the-counter and prescription medications so that they are only accessible to appropriate office personnel. Prescription pads that are inaccessible to patients.	Process for dating and rotating stock medications Routine monitoring of drug stock expiration dates Disposal process for expired medications in accordance with applicable hazardous waste laws Storage for controlled substances and medications in accordance with state and federal laws
Infection Control	Process for disposing hazardous waste that includes using designated colored trash bags (red, yellow, red striped) for hazardous waste and sharps containers (per state laws if applicable)	Effective sterilization/disinfection methods for instruments and equipment used for more than one patient, including periodic sterilizer spore testing and instrument soaking process using the proper solutions

* If a provider is not available after regular office hours, he or she must arrange for similar specialty provider coverage (in accordance with the Select Health covering provider policy). Rural area providers may direct their phone and/or patients to the hospital for coverage.

25.0 Subrogation

The Subrogation team is involved in situations when a member is injured in an accident or event where there may be a third party at fault. The following subsections outline the most common examples of cases handled by the Subrogation team.

25.1 Automobile Accidents

Subrogation reviews the circumstances of all auto accidents, any type of motorized vehicle accidents, and auto vs. pedestrian or bike accidents. If another party is at fault for our members' injuries, the claims are processed according to normal benefits. Subrogation then coordinates with lawyers, auto insurance companies and member to ensure that once a settlement is reached, Select Health is reimbursed for claims paid.

25.2 Worker Compensation

When an injury is determined to be an industrial accident, all claims with related diagnosis will be denied. If the WC carrier denies the claim, we need to obtain a copy of that denial before we can pay claims. After the denial is received, Select Health becomes primary and processes claims according to benefits. When a provider receives duplicate payment from both Select Health and a workers compensation carrier, they should call Select Health and request our payment be taken back.

25.3 Third Party Liability (TPL)

This category covers most accidental injuries not listed above, including, but not limited to:

- Injuries in a public place
- Injuries that occur in a home
- Slip & fall injuries
- Hit by an object
- Church ball games

These claims are usually paid by Select Health. Subrogation researches each case to determine if another party should pay, in which case, Select Health would eventually be reimbursed for any claims paid. Some possible payers would be homeowners insurance or property insurance.

25.4 Medical Malpractice

If a member feels they received medical care where the outcome was not satisfactory and they feel it was due to negligence on the part of a medical provider or medical facility, they may file a medical malpractice suit against a provider or facility. Select Health pays the member's medical claims according to normal benefits. The Subrogation team works with the member's attorney or risk management to determine how much money will be reimbursed if the malpractice case is won.

26.0 Utilization Management Incentives Policy

UM staff are available to discuss UM issues from 8:00 am to 5:00 pm, Monday through Friday. Inbound communication via fax is available after normal business hours for UM issues at **801-442-0825**.

The following Select Health policy addresses financial incentives related to utilization and utilization management (UM) decisions:

1. UM decision-making by Select Health employees is to be based on the appropriateness of care and service and the existence of coverage.
2. Select Health does not specifically reward providers or other individuals who conduct UM for issuing denials of coverage or service care, either in particular cases or generally.
3. Select Health does not provide financial incentives for UM personnel that encourage decisions that result in under-utilization of services otherwise needed by members.

Select Health Medical Criteria Sets are available for providers to review upon request. To request information, providers should call **801-442-4305** or **800-442-4305**.

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Appendix A: Select Health Medicare-Specific Information

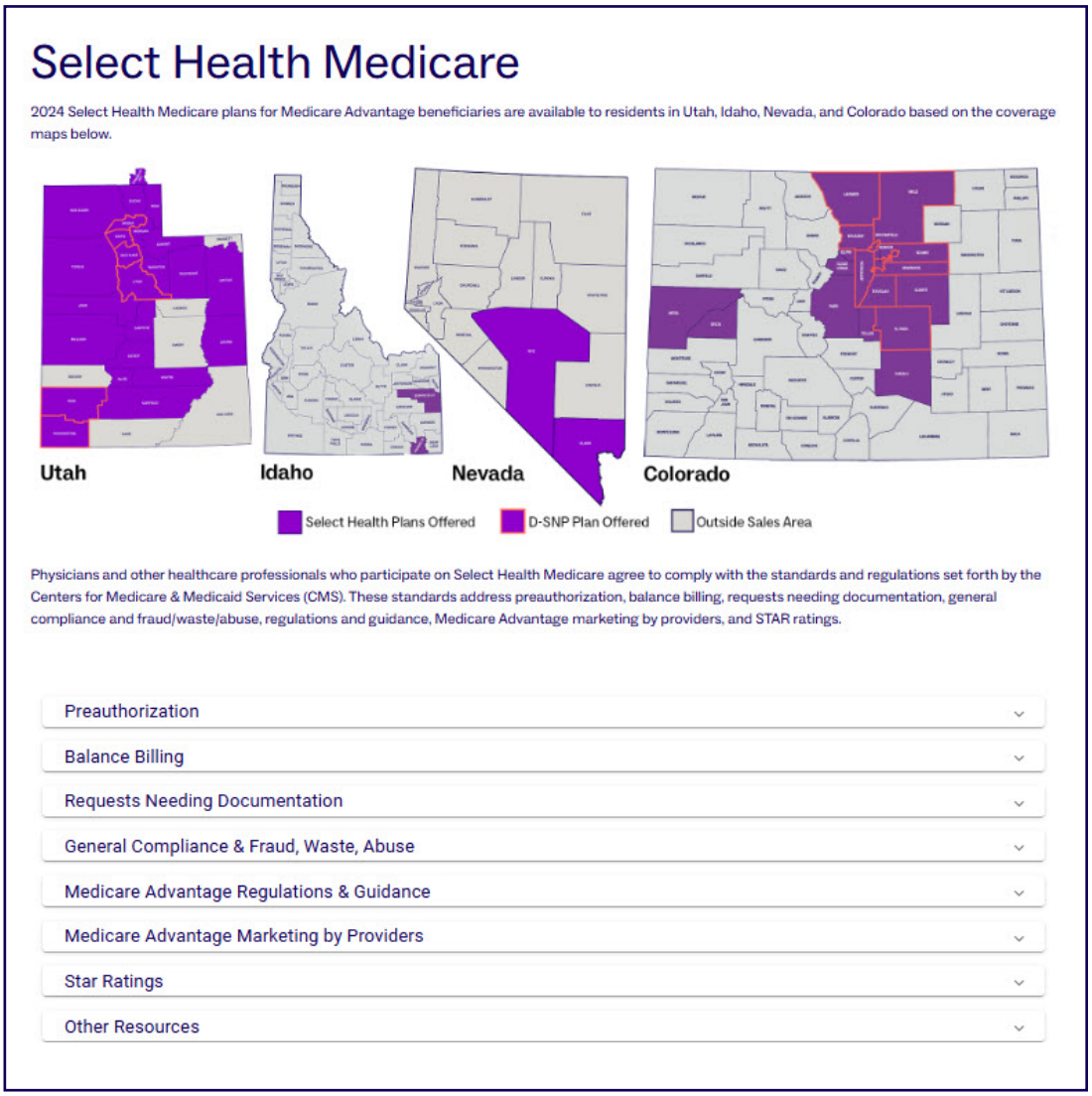
Introduction

Select Health Medicare
P.O. Box 30196
Salt Lake City, UT
84130-0196

Physicians and other healthcare professionals who participate on Select Health Medicare agree to comply with the standards and regulations set forth by the Centers for Medicare & Medicaid Services (CMS). These standards address preauthorization, balance billing, requests needing documentation, general compliance and fraud/waste/abuse, regulations and guidance, Medicare marketing by providers, and STAR ratings. Access information on these topics on the Select Health provider website (see **Figure 5** below).

The information on the following pages covers those topics indicated throughout this manual that have Medicare-specific details.

Figure 5. Select Health Medicare Online Resources



Appendix A: Select Health Medicare-Specific Information, Continued

Other Party Liability

Coordination of Benefits

Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing a claim. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including but not limited to: group health insurance, retiree benefits, auto insurance, and workers compensation.

NOTE: Select Health Medicare will be the primary insurance carrier over individual and inactive group plans.

Beneficiaries must be eligible for Original Medicare parts A and B to elect coverage with a Select Health Medicare plan. Select Health Medicare plans administer the benefits, process and pay claims, but they are separate from Original Medicare. Beneficiaries are eligible under three status types: Working Aged, Disability and End-Stage Renal Disease (ESRD).

The following are guidelines related to how Select Health Medicare® plans coordinate benefits with group health insurance policies:

1. **Select Health Medicare Working Aged:**
   - Active employer group insurance plans are primary to Select Health Medicare if the group has 20 or more employees.
   - Active employer group insurance plans are secondary to Select Health Medicare if the group has less than 20 employees.
2. **Select Health Medicare Disability:**
   - Active employer group insurance plans are primary to a Select Health Medicare if the group has 100 or more employees.
   - Active employer group insurance plans are secondary to Select Health Medicare if the group has 99 or fewer employees.
3. **Select Health Medicare End-Stage Renal Disease (ESRD):**

   During the first 30 months of eligibility (referred to as the "coordination period") any group health plan is primary to Select Health Medicare. After the coordination period, Select Health Medicare will become the primary insurance policy.

Auto, Workers' Compensation, and Other Liability Insurance

Select Health Medicare does not pay for items or services to the extent that payment has been, or may reasonably be expected to be, made through a no-fault or liability insurer or through Workers' Compensation (WC). Select Health Medicare may make a conditional payment when there is evidence that the primary plan does not pay promptly conditioned upon reimbursement when the primary plan does pay. Subrogation is responsible for recovering conditional payments when there is a settlement, judgment, award, or other payment made.

Appendix A: Select Health Medicare-Specific Information, Continued

Hospice

When subrogation has information concerning a potential recovery situation, it will identify the affected claims and begin recovery activities. Beneficiaries and their attorney(s) should recognize the obligation to reimburse Select Health Medicare during any settlement negotiations.

Hospice services related to terminal conditions are paid for by Original Medicare Part A and Part B, not Select Health Medicare.

Medicare-Approved Clinical Trials

Original Medicare is responsible for the primary payment of approved clinical trials. Select Health Medicare will process these claims as secondary. Medical records may be requested.

Subrogation

The Subrogation team is involved in situations when a member is injured in an accident or event where a third party may be at fault.

All claims involving a personal injury case will be processed by Select Health, following all applicable COB rules, then sent to the state Office of Recovery Services (ORS) for subrogation to recoup any third-party liability.

Appendix A: Select Health Medicare-Specific Information, Continued

Medical Necessity and Prior Authorization

Questions? Call Select Health Medicare Member Services at **855-442-9900**.

Healthcare services, equipment, and supplies must be medically necessary to be covered. In addition, only services that are covered by Select Health Medicare will be eligible for reimbursement.

Per Utah Medicare and CMS regulations healthcare services or products are considered "medically necessary" if a prudent healthcare professional would provide them to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms.

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered, e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in their home unless it was a reasonable and necessary part of the patient's treatment. See also §80. A health care item or service for the purpose of causing, or assisting to cause, the death of any individual (assisted suicide) is not covered. This prohibition does not apply to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing death.

It is the responsibility of a contracted provider to confirm medical necessity based on Select Health and CMS guidelines.

The fact that a provider—even a participating provider— may prescribe, order, recommend, or approve healthcare services, equipment, care, or supplies does not establish medical necessity, even if not listed as an exclusion or limitation.

Medicare Preauthorization and InterQual® Criteria

Select Health Medicare requires the Request for Preauthorization (RPA) form for all preauthorization requests for all Select Health members. This includes commercial products, Select Health Medicare, and Select Health Community Care. Access the **Preauthorization area** of the provider website where you can access and download relevant lists of medical procedures requiring preauthorization as well as request forms.

To view a list of medications that require preauthorization and to access our online pharmacy preauthorization tool (PromptPA), access **Drugs with Special Requirements (Medicare)**.

Notification of Select Health alone does not qualify as completion of the preauthorization process.

Appendix A: Select Health Medicare-Specific Information, Continued

Time Frames for Organization Determinations

An enrollee or any physician may request that Select Health expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

An expedited organization determination occurs as expeditiously as the enrollee's health condition requires, but **no later than 72 hours** after Select Health receives the request.

Standard medical requests are processed **within 14 calendar days**. If it is in the best interest of the member to obtain more information, Select Health may extend this time frame by **45 days**.

Responsibilities of the Requesting Provider

The requesting provider must:

- Provide Select Health with documentation of medical necessity
- Request services based on medical coding (ICD-9/10, CPT, etc.), and provide these codes to Select Health benefit determination using the following contact information:

Fax:	**877-228-0517**
Phone:	**800-442-5305**
U.S. Mail:	Attention: Health Services, Select Health VCT 5th Floor, 5381 Green Street Murray, UT 84123
Email/Scan:	**benefit.determination@selecthealth.org**

Forms and InterQual® Criteria

When CMS does not have a coverage policy, **InterQual criteria** will be used. If InterQual criteria is unavailable, Select Health medical necessity policy will be applied.

The Select Health **Request for Preauthorization Form** must be completed by the provider (if not using the Preauth & Care Plan Tool or PromptPA).

Criteria used for medical preauthorization will follow CMS Medicare coverage guidelines found in the Medicare Coverage Database and Internet-Only Manuals.

Lack of Preauthorization

If a contracted or non-contracted provider submits a claim for a service that requires preauthorization but has not been preauthorized, the service will be denied. If additional records are submitted, then the claim will undergo retrospective medical review with medical records. Appropriate preauthorization criteria will be applied, as above.

If the service is found to be medically necessary, the claim will be paid, but the provider will be sanctioned with a payment reduction of 25 percent of the allowed amount. Members may not be balance billed for the sanctioned amount.

Appendix A: Select Health Medicare-Specific Information, Continued

If the service is found to NOT be medically necessary or not a covered service, the claim will be denied to the provider. Members may not be balance billed for denied charges.

If the provider is unwilling or unable to provide medical records, the claim will be denied for lack of information. Members may not be balance billed for denied charges.

Balance Billing

Select Health Medicare members may not be balance billed by contracted or non-contracted providers for denied services unless a pre-service denial has been obtained.

No Medicare cost sharing will be imposed on Dual Eligible members (including but not limiting to Dual Special Needs Medicare Plan (DSNP) members. Select Health will require the provider to accept payment from Select Health as payment in full or bill the Department or Medicaid plan for the cost share portion and accept as payment in full.

Select Health, along with all providers, suppliers, and pharmacies, must refrain from collecting Medicare cost sharing for Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) and Dual Eligible Special Needs Plan (D-SNP), or any dually eligible program that exempts individuals from medicare cost-sharing liability.

Select Health can provide real-time information and indicators (through automated eligibility-verification systems, online provider portals, and phone query mechanisms) and clearly indicate members owe $0 directly on the Explanations of Payment statements for providers and on member identification cards. Providers cannot discriminate against enrollees based on their payment status (e.g., specifically), and providers may not refuse to serve enrollees because they receive assistance with Medicare cost sharing from a State Medicaid program.

Denial and Appeals

If a request for preauthorization is denied, a written appeal for further review of the request can be filed. Providers may use the **Provider Appeal Form**.

For urgent requests, the provider may request an expedited appeal verbally or in writing. For verbal requests, call Member Services at **1-800-222-6358.**

When a medical record review confirms that a service requiring preauthorization did not undergo review because it was provided emergently or unexpectedly to the enrollee, the service will be reimbursed to the provider at the usual allowed amount (if criteria were met). This exception to the usual sanctioning for lack of preauthorization does not apply to excluded services.

Appendix A: Select Health Medicare-Specific Information, Continued

Member Appeals and Grievances

Filing an Appeal

Questions about the appeals process?
Call Member Services at **1-800-222-6358**.

If we make a coverage decision and a Select Health Medicare member is not satisfied with the decision, they can file an appeal. An appeal is a formal request to change a coverage determination that we have made.

When an enrollee files an appeal, we review the original coverage determination and all information submitted with the appeal. Appeals are reviewed by different individuals from those who made the original determination.

Pre-Service Level 1 Appeals

As a Select Health Medicare network provider, you can request a Pre-service Level 1 appeal on behalf of the enrollee. If the appeal is denied at Level 1, it will forward automatically to Level 2. To request any appeal after Level 2 you must be appointed as the enrollee's representative. If an enrollee wants to appoint you as his or her representative, both you and the enrollee must complete the "**Appointment of Representative**" form. This form is available on the Select Health Medicare website and gives you permission to act on behalf of the enrollee. It must be signed by the enrollee and by the person who would like to act on his or her behalf, and then submitted to us with the appeal.

Providers can use the **Provider Appeal Form** to initiate a pre-service appeal; email the completed form to **appeals@selecthealth.org**.

To initiate a Pre-Service Level 1 appeal on behalf of a member, you must contact us within **60 calendar days** from the date of the coverage determination.

You may submit any additional information you would like us to review in conjunction with the appeal. We will also gather information. If necessary, we will contact you or the enrollee to obtain more information.

Expedited Appeals

Expedited appeals may be submitted verbally or in writing. Expedite an appeal by calling Member Services at **1-800-222-6358**.

If we do not provide you and the enrollee a determination within 72 hours (or, if we took extra days, by the end of the extended time period), we are required to automatically send the request on to Level 2 for review by an independent review entity contracted with the Centers for Medicaid and Medicare Services (CMS).

If our answer is yes to part or all of your request, we will authorize or provide the coverage we have agreed to provide within 72 hours after we receive the appeal.

If we agree with our original determination, we will send you and the enrollee a written notice informing you that the appeal has been sent to the independent review entity for an automatic Level 2 appeal.

Appendix A: Select Health Medicare-Specific Information, Continued

In the case of an expedited appeal at Level 1, the review entity will provide their determination on the Level 2 appeal within 72 hours of when it receives the appeal. However, if the independent review entity needs to gather more information that may benefit the enrollee, it can take up to 14 more calendar days.

You have the right to request a copy of the information related to the determination of the appeal.

Standard Appeals (Part C only)

For standard Part C appeals, we will make our determination **within 30 calendar days** of the date we receive the appeal. We will make a determination sooner if required by the enrollee's health condition. However, if you ask for more time to provide us information, or if we need to gather more information that may benefit the enrollee, we may take up to **14 more calendar days** to make our determination.

If you are asking for a standard appeal, you may file the appeal in writing either via U.S. mail or by fax as follows:

Select Health Medicare
P.O. Box 30196
Salt Lake City, UT 84130-0196

Fax: **801-442-0762**
Email: **appeals@selecthealth.org**

If we do not provide you and the enrollee a determination by the deadline above (or, if we took extra days, by the end of the extended time period), we are required to send the request on to Level 2 of the appeals process, where it will be reviewed by an independent review entity contracted with CMS.

If our answer is yes to part or all of your request, we will authorize or provide the coverage we have agreed to provide within 30 days after we receive the appeal.

If we agree with our original determination, we will send you and the enrollee a written notice informing you that the appeal has been sent to the independent review organization for an automatic Level 2 appeal. Reviewers at the independent review organization will consider all information related to the appeal.

If the case was a standard appeal at Level 1, the review entity will provide their determination on the Level 2 appeal within 30 calendar days of when it receives the appeal. However, if the independent review entity needs time to gather more information that may benefit the enrollee, it can take **up to 14 more calendar days**.

If the review organization says yes to part or all of the appeal, Select Health will authorize the medical care **within 72 hours** or provide coverage for the requested service **within 14 calendar days** after we receive the decision from the review organization.

If the review organization says no to part or all of the appeal, it means they agree with the determination made by Select Health.

The written notice the enrollee gets from the independent review organization will tell them specific conditions and instructions for continuing with the appeals process.

Appendix A: Select Health Medicare-Specific Information, Continued

As the enrollee's doctor, you can request both a Level 1 or Level 2 appeal on behalf of the enrollee for prescription drugs. To request any appeal after Level 2, the doctor or any other prescriber must be appointed as the representative of the enrollee. (See the "**Appointment of Representative**" form).

Part D Appeals

For standard Part D appeals, we will make our determination **within seven calendar days** from the time we receive the appeal. If the enrollee has not yet received the drug and their health condition requires a faster turnaround time, we will make our determination sooner.

If we do not make our determination within seven calendar days, we are required to send the request on to Level 2, where it will be reviewed by the independent review organization.

If we approve a request for coverage, we will provide the coverage we have agreed to provide as quickly as the enrollee's health requires, but no later than seven calendar days after we receive the appeal.

If we approve a request to reimburse the enrollee for a drug he or she purchased, we are required to send payment to the enrollee within **30 calendar days** after we receive the appeal request.

For expedited (fast) Part D appeals, we will make our determination **within 72 hours** from the time we receive the appeal. If the enrollee has not yet received the drug and his or her health requires a faster turnaround time, we will make our determination sooner.

If we do not make our determination within 72 hours, we are required to automatically send the request on to Level 2, where it will be reviewed by the independent review organization.

If our answer is yes to part or all of what you requested, we will authorize or provide the coverage we have agreed to provide **within 72 hours** after we receive your appeal.

If we agree with our original determination, the written notice we send will include instructions on how the enrollee can make a Level 2 appeal with the independent review organization. These instructions indicate who can initiate this Level 2 appeal, the deadlines that must be followed, and how to reach the review entity.

Appendix A: Select Health Medicare-Specific Information, Continued

Medicare Preventive Benefits

Coverage of preventive services for Select Health Medicare® (Medicare) follows the coverage guidelines for traditional Medicare. Covered preventive services can be found on the online interactive **CMS Quick Reference Chart**, which includes guidelines and codes for all preventive services that are covered for Medicare and Medicare patients with no copays or coinsurance for the patient.

Annual Wellness Visit (AWV)

A comprehensive physical exam is not on the coverage list for Medicare patients because it is not recommended by the U.S. Preventive Services Task Force (USPSTF). Instead, an AWV is covered (see the **CMS Medicare Wellness Visits** educational tool).

The AWV includes a Health Risk Assessment (HRA), which is completed by the patient and should be used by a provider to establish a personalized care plan for each patient. Select Health® will send an HRA to every Select Health Medicare enrollee when they sign up for the plan. When the enrollee returns the HRA to Select Health, the form will be sent to the primary care physician's office so that it is available for providers.

Combination Visits for Select Health Medicare Members

To encourage members to receive an annual comprehensive medical exam, Select Health covers combination visits, a preventive exam or Evaluation and Management (E&M) visit, on the same date of service as an AWV. Documentation must support both codes and include evaluation and assessment of all chronic medical conditions, current treatment plan for each condition, and medical conditions coded with accurate and specific ICD-10 coding.

Figure 6 on the next page presents code combinations for identifying services rendered for the comprehensive exam.

Appendix A: Select Health Medicare-Specific Information, Continued

Figure 6. Code Combinations for Comprehensive Exam

AWV plus:	Code Combination (1 and 2)	Modifier/Notes
Preventive Exam, Initial Visit	G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit 99387 Initial comprehensive preventive medicine evaluation and management 65 years and older	No modifier needed
Preventive Exam, Subsequent Visit	G0439 Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit 99387 Initial comprehensive preventive medicine evaluation and management 65 years and older	
E&M, Initial Visit*	G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit 99201–99205 Office visit for evaluation and management of a new patient, minor high severity	A modifier 25 must be added to 99201–99205 procedure codes.
E&M, Subsequent Visit*	G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit 99211–99215 Office visit for evaluation and management of an established patient, minimal to high severity	A modifier 25 must be added to 99211–99215 procedure codes.

* Member copay applies to E&M service per his or her Member Payment Summary (MPS).

Appendix A: Select Health Medicare-Specific Information, Continued

Medicare Advantage Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates the quality of care and customer service of all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a five-star rating system.

Medicare Advantage plans, such as Select Health Medicare, are assessed on an annual basis and ratings may change from one year to the next. Each plan is assigned a score based on a 1 to 5 star scale.

Star ratings provide Medicare beneficiaries a standardized way to compare plans based on quality and performance. This information gives consumers, families, and caregivers data they can use to make an educated decision about their healthcare needs and choose an appropriate health plan.

Star ratings are published on the CMS website for members to use in evaluating health plans during the Annual Enrollment Period (AEP). Plans with a five-star rating receive a "High Performing Icon" on the website and plans with less than a three-star rating for the past three years receive a "Low Performing Icon" on the website. Plans are also eligible for a bonus in premium from CMS if they have a four-star or higher rating.

Star Rating Measures

Current star ratings are based on categories including preventive care, managing chronic conditions, member satisfaction, and customer service and pharmacy benefits. The data sources used by CMS to develop star ratings include:

- **HEDIS® (Healthcare Effectiveness Data and Information Set)**: Clinical performance indicators (access to care, receipt of preventive services, and management of chronic conditions). **Examples of HEDIS measures** are as follows:
  - Breast cancer screening
  - Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis
  - Osteoporosis management in women who had a fracture
  - Use of high-risk medications in the elderly
  - Plan all cause readmissions
  - Documentation of body mass index (BMI) once in prior two years
  - Colorectal cancer screening – colonoscopy in the past 10 years, sigmoidoscopy in the past five years, or annual fecal occult blood test (FOBT)
  - Hypertension control less than 140/90 mmHg
  - Diabetes blood sugar control, eye exams, and nephropathy monitoring

Appendix A: Select Health Medicare-Specific Information, Continued

- **CAHPS (Consumer Assessment of Healthcare Providers and Systems)**: A member survey conducted annually to assess the experiences of members in Medicare Advantage and Prescription Drug Plans with their health plan and providers. **Examples of CAHPS measures** include:
  - Getting appointments and care quickly
  - Rating of health care quality, health plan, and drug plan
  - Care coordination
  - Annual flu vaccine
- **Medicare Health Outcomes Survey (HOS):** Surveys members about their perceptions of their physical and mental health over a two-year period to assess whether members have maintained or improved their health. HOS also collects health characteristic information such as chronic conditions and limitations in Activities of Daily Living (ADL). **Examples of HOS measures** are as follows:
  - Monitoring physical activity
  - Improving bladder control
  - Reducing the risk of falling
  - Improving or maintaining physical and mental health
- **Administrative and Compliance Measures:** Call center performance, grievance and appeals, CMS audits, and member complaint tracking.
- **Part D (Pharmacy) Measures:** Medication adherence (oral diabetics, hypertension, and cholesterol medications) and accuracy of drug pricing and member experience.

Improving Star Measures

Questions about our Medicare Star ratings and initiatives? Contact Provider Development at **800-538-5054**.

NOTE: For general information about the CMS Star Rating System or to view current Star Ratings for Medicare Advantage and Part D plans, please visit the CMS consumer website.

Select Health encourages participating providers to **help improve Star rating** measures by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual
- Educating members and talking to them during each visit about their preventive health care needs and disease management goals
- Ensuring providers answer any questions members have regarding newly prescribed medications
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle
- Conducting annual wellness visits with particular focus on urinary incontinence, fall and balance problems, and monitoring and increasing physical activity levels
- Closing Gaps in Care based on the Gaps-in-Care Reports distributed to your office

Appendix A: Select Health Medicare-Specific Information, Continued

Risk Adjustment

Medicare Advantage (MA) plans receive payments from the Centers for Medicare and Medicaid Services (CMS) to cover healthcare costs of members of that MA plan. These payments allow the MA plans to pay medical costs of the members, and also to offer more robust benefits and services than Fee-For-Service Medicare, such as fixed co-payments, wellness benefits, care management, and local customer service, among others. Patients who enroll in MA plans appreciate these additional benefits and services, which could not be offered without the CMS payments to the MA plan.

The payment amounts to MA plans that allow for the additional benefits and services are based on the health and chronic medical conditions of members in the plan, as determined by physician documentation and coding of the MA enrollees' chronic medical conditions. Therefore, the ability of the MA plan to be successful is similarly dependent on the accuracy of physician documentation and coding of chronic medical conditions.

The process to determine the health and chronic medical conditions of the members for the purpose of calculating payments to the MA plan is called "Risk Adjustment." The methodology assigns a Risk Adjustment Factor (RAF) or "risk score" to each Medicare Advantage member. Each member's risk score is multiplied by a fixed dollar amount, based on where the member lives, to determine the expected costs of providing care for that member. The resulting amount is what CMS pays the MA plan to cover their members' medical costs, benefits, and plan-related services.

Risk scores are derived from the diagnosis codes reported on physician and hospital inpatient and outpatient claims data during a one-year time frame. Therefore, accurate and complete diagnosis (ICD-10) coding is essential to appropriately reflect the chronic medical conditions and expected costs of the MA membership. Only codes for chronic conditions that would be expected to increase healthcare costs are included in the calculation of the risk score. Consequently, coding with greater specificity results in more accurate representation of the risk score than reporting nonspecific codes.

Codes for acute or nonspecific conditions and redundant codes (two codes for different varieties of the same condition) are not included in the risk scoring. The more specific the coding, the more accurate the risk score, with a resulting payment to the MA plan that more closely reflects the health status/illness burden of the individual MA member.

We have several training opportunities available, including presentations and workshops, printed materials, and in-person training. Contact Provider Relations at **800-538-5054** or via email at **provider.development@selecthealth.org** to learn more about these training opportunities.

Appendix A: Select Health Medicare-Specific Information, Continued

Documentation and Coding Tips

Follow these guidelines for more accurate documentation:

- **Document every condition every year**: Schedule and see every patient annually.
- **Every record must include**:
  - Patient name
  - Provider signature and credentials (MD, DO, NP)
  - Date of service
  - Describe the current condition
  - Include **MEAT** for each diagnosed condition — **M**onitored, **E**valuated, **A**ssessed, or **T**reated:
    - **Monitored** – Must indicate that you asked about the current status of the condition;
    - **Evaluated** – Exam or lab/imaging findings;
    - **Assessed** – Note the current medical status of the patient's condition; **or**
    - **Treated** – Record the treatment plan; may state "continue current plan" if current plan is documented.
- **Document all relevant conditions yearly:**
  - Chronic conditions (diabetes, heart failure, COPD)
  - Active status conditions (amputations, ostomy)
  - Pertinent past conditions (previous cancers, previous stroke)
  - All conditions being treated with medication
- **Be specific:**
  - Major depression vs. depression
  - Chronic bronchitis vs. bronchitis
  - Atrial fibrillation vs. dysrhythmia
  - Chronic kidney disease should be staged I-V
  - Skin ulcer vs. open wound
  - Morbid obesity with BMI >40 vs. obesity
  - Angina vs. chest pain
  - Malnutrition vs. weight loss
- **Code multiple conditions when applicable:**
  - Diabetes with retinopathy/nephropathy/neuropathy
  - Coronary artery disease with previous MI/hypertension/ hyperlipidemia/afib/angina

Appendix A: Select Health Medicare-Specific Information, Continued

  - CVA with hemiplegia/dysarthria/dysphagia
  - CKD with staging (I-V)/dialysis status
  - Cirrhosis due to alcohol dependence
  - Infection with organism (if known)
- **Include psychosocial diagnoses**:
  - Major depression (rather than just "depression," when appropriate)
  - Lifetime illnesses (schizophrenia, bipolar disorder)
  - Alcohol/drug dependence
- **Avoid "Rule Out" in the diagnosis, since this does not confirm the condition.**

Coding Tips Based on the Optum Physician Pricer

Select Health has partnered with Optum to use their system for Medicare pricing, payment, and claims editing and adjudication for all participating providers in Utah and Idaho; hospitals are excluded at this time. This partnership facilitates better alignment with CMS payment methodologies.

As a result, providers may need to alter some billing practices to be more in line with Medicare. One area of specific impact is the use of LT, RT, and 50 modifiers. **NOTE**:

- You will need to bill 50 modifiers instead of LT/RT as outlined by CMS.
- Select Health will pay 50 modifiers in accordance with CMS guidelines.
- If an LT and an RT are billed, the claim may be tagged with Medically Unlikely Edit (MUE) and denied. In this case, a 50 modifier may need to be billed instead.

Multiple Procedure Discounting Update: The Optum Physician Pricer applies many different types of multiple-procedure discounting, just like CMS, to physician and non-physician practitioner claims, including discounting for:

- Endoscopic procedures
- Diagnostic imaging
- Therapy service
- Surgical procedures
- Cardiovascular procedures
- Ophthalmology procedures

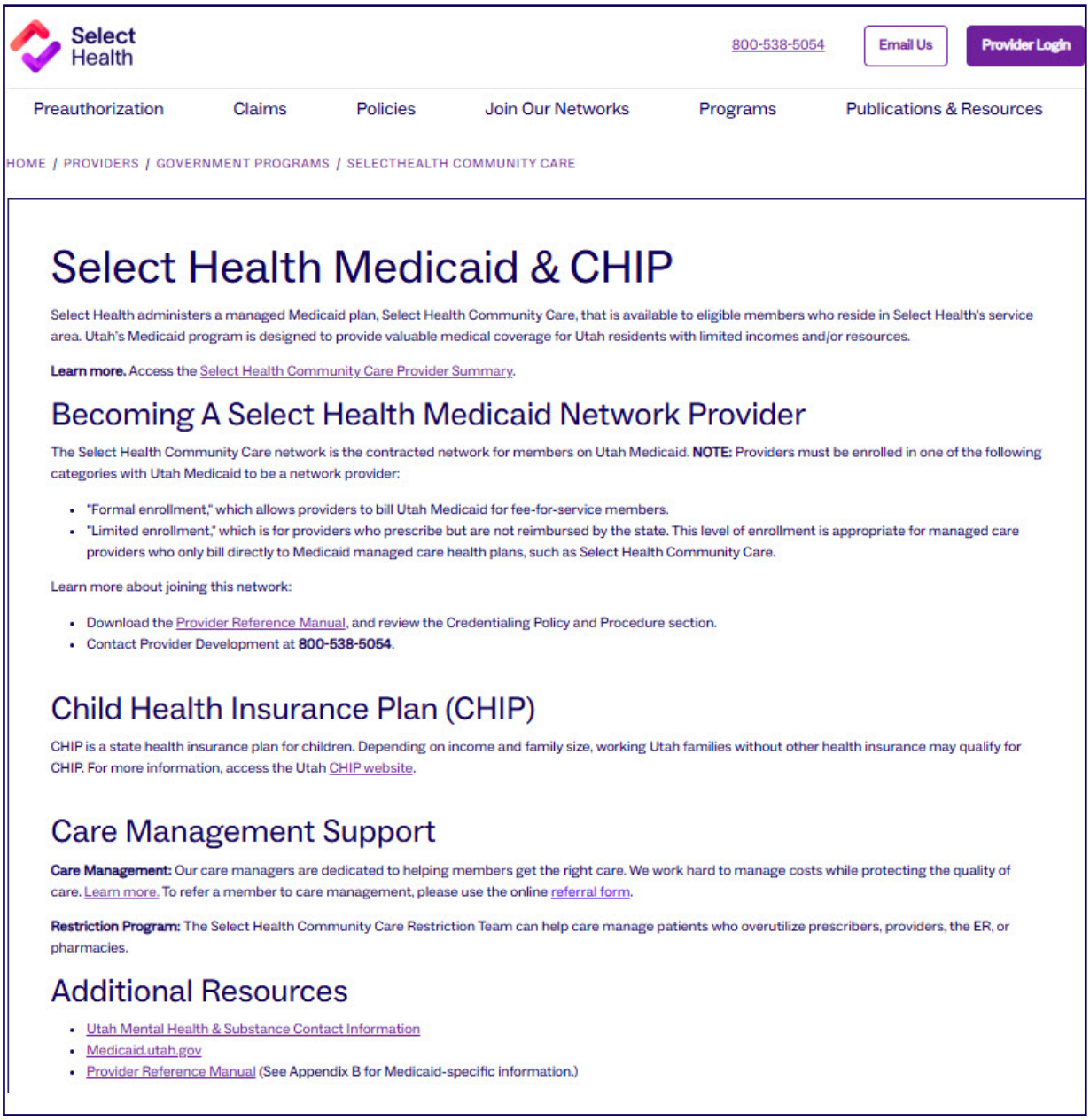
Appendix B: Select Health Community Care®-Specific Information (Utah Medicaid)

Questions?
Contact Select Health Community Care Member Services at **800-538-4234.**

Physicians and other healthcare professionals who participate on Select Health Community Care (Medicaid) access information on these topics on the Select Health provider website (see **Figure 7** below).

The information on the following pages covers those topics from this manual that have Medicaid-specific details. You can also access informative publications on the Utah Medicaid site.

Figure 7. Select Health Community Care Online Resources



Appendix B: Select Health Community Care-Specific Information, Continued

Critical Incident Reporting

Currently, critical incident reporting is a requirement of the Utah Department of Health and Human Services (DHHS) for only the Utah Medicaid Integrated Care (UMIC) plans.

Providers are required to report any/all critical incidents to Select Health and/or to DHHS as soon as identified; Health plans, like Select Health Community Care, submit the list of critical incidents reported (if any) to the DHHS quarterly.

Select Health must report the items listed in **Figure 8** below. Providers may be required to report additional critical incident types based on state agreement requirements.

Providers may report the critical incident to Select Health, either to Provider Development or to Healthy Connections and/or the Department of Health and Human Services (DHHS).

Questions? Contact your Provider Relations representative or Healthy Connections.

Figure 8. Types of Critical Incidents and Required Reporting

Critical incident requiring quarterly reporting (e.g., 04.01.24 – 06.30.24, 07.01.24 – 09.30.24, etc.)
• A serious injury of a member that occurred on the behavioral health facility premises and required an overnight admission to a hospital medical unit • A report of a serious physical assault of or by a member that: — Occurred on the behavioral health facility premises — Required medical intervention at a medical facility/medical unit/emergency department (for the assailant if assault by the member) • An unexpected death of a member that occurred on behavioral health facility premises • A report of a sexual assault of or by a member that occurred on behavioral health facility premises • A report of an abduction of a member that occurred on behavioral health facility premises • An instance of care ordered or provided to a member by someone impersonating a healthcare professional, that occurred on the behavioral health facility premises • Prepaid Mental Health Plan (PMHP) provider medication errors resulting in an impact on the member's well-being, medical status, or functioning
Critical incidents reported quarterly BUT ALSO requiring that if the incident occurred within 30 days of discharge from behavioral health services and, if it is known, it must be reported
• A serious suicide attempt by a member that required an overnight admission to a hospital medical unit • A completed suicide by a member • A homicide attributed to a member

Medicaid Preauthorization and InterQual® Criteria

Select Health Community Care requires the Request for Preauthorization (RPA) form for all preauthorization requests for all Select Health members as do commercial plans and Select Health Medicare. In the **Preauthorization area** of the provider website you can access and download relevant lists of medical procedures requiring preauthorization as well as request forms.

To view a list of medications that require preauthorization and to access our online pharmacy preauthorization tool (**PromptPA**), visit **Drugs with Special Requirements (Medicare)**.

Notifying Select Health alone does not qualify as completion of the preauthorization process.

Time Frames for Preauthorization

Medically urgent requests are processed **within 72 hours** of receipt of the request.

Standard medical requests are processed **within 14 calendar days**.

If it is in the best interest of the member to get more information, Select Health may extend this time frame by 14 days.

Responsibility of the Requesting Provider

The requesting provider must:

- Provide Select Health with documentation of medical necessity.
- Request services based on medical coding (ICD-9/10, CPT, etc.), and provide these codes to Select Health benefit determination using the following contact information:

Fax: **877-228-0825** Phone: **800-442-0625**
U.S. Mail: Select Health
Healthy Connections Dept
5381 S Green St
Murray, UT 84123

Email/Scan: **medicaidumintake@imail.org**

Forms and Criteria

The Select Health **Request for the Preauthorization Form** must be completed by the provider.

Criteria used for medical preauthorization will follow Utah Medicaid guidelines for Select Health Community Care enrollees.

Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual®. There may be situations where Select Health commercial policies or CMS' National Coverage Determination/Local Coverage Determination criteria are used.

Appendix B: Select Health Community Care-Specific Information, Continued

Lack of Preauthorization

If a contracted or non-contracted provider submits a claim for a service that requires preauthorization but has not been preauthorized, the service will be denied. If additional records are submitted, then the claim will undergo retrospective medical review with medical records. Appropriate preauthorization criteria will be applied, as above.

If the service is found to be medically necessary, the claim will be paid, but the provider will be sanctioned with a payment reduction of 25 percent of the allowed amount. Members may not be balance billed for the sanctioned amount.

If the service is found to be not medically necessary or not a covered service, the claim will be denied to the provider. Members may not be balance billed for denied charges.

If the provider is unwilling or unable to provide medical records, the claim will be denied for lack of information. Members may not be balance billed for denied charges.

Balance Billing

Select Health Community Care members may not be balance billed by contracted or non-contracted providers for denied services **unless**:

- The provider has an established policy for billing all patients for services not covered by a third party.
- The patient is advised prior to receiving a non-covered service that the plan will not pay for the service.
- The patient agrees to be personally responsible for the payment.
- A written agreement is made between the provider and the patient that details the service and the amount to be paid by the patient.
- The **Medicaid Financial Agreement Form** should be completed by the provider and member.

When these requirements are met, the remittance advice may still show contractual obligation, but balance billing may be appropriate.

Denial and Appeals

If a request for preauthorization is denied, providers can file an appeal for further review of the request using the **Provider Appeal Form**.

For urgent requests, the provider may request an expedited appeal verbally or in writing. For verbal requests, call Member Services at **1-800-222-6358.**

When a medical record review confirms that a service requiring preauthorization did not undergo the relevant review because it was provided emergently or unexpectedly to the enrollee, the service will be reimbursed to the provider at the usual allowed amount. This exception does not apply to excluded services.

Appendix B: Select Health Community Care-Specific Information, Continued

Standard Appeals Process

Timing: The Aggrieved Person may file an Appeal within 60 calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination.

Agreements with Providers and Subcontractors:

The Contractor shall inform Providers and Subcontractors at the time they enter into a contract about **all of the following**:

- The Grievance, Appeal, and State Fair Hearing procedures and time frames as specified in 42 CFR 438.400 through 42 CFR 438.424.
- The Aggrieved Person's right to request a State Fair Hearing after the Contractor has made a determination on the Enrollee's Appeal that is adverse to the Enrollee.
- If the Contractor makes an Adverse Benefit Determinations to reduce, suspend, or terminate services, then **both apply**:
  - The Enrollee, the Enrollee's legal guardian, or other authorized representative has the right to request that the services be continued pending the outcome of the Appeal or State Fair Hearing if the Enrollee requests continuation of services within the required time frame.
  - If the Appeal or State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of services.

Additional Notes about Denials and Appeals

Behavioral health benefits must be coordinated through the member's EAP representative, if applicable.

For questions regarding pharmaceutical preauthorization requirements, call the Select Health Pharmacy Help Desk at **801-442-4912** (for the Salt Lake area) or **800-442-3129**.

Providers requesting a peer-to-peer discussion on a benefit determination may call **801-442-5305**.

Select Health Medical Criteria Sets are outlined in each medical policy. Criteria are also available upon request by calling **800-442-5305**. Please specify if you would like to receive the criteria via mail, fax, or email.

Health Services staff are available to discuss utilization management (UM) issues from 8:00 a.m. to 5:00 p.m., Monday through Friday. After normal business hours, fax UM questions to **801-442-0517**.

Appendix B: Select Health Community Care-Specific Information, Continued

Other Party Liability

Coordination of Benefits

Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including other health insurance, retiree benefits, auto insurance, workers compensation, etc.

For members on Select Health Community Care, the Medicaid program is the usually the payer of last resort, meaning all other payers are considered before Medicaid. Select Health is the primary payer for exceptions related to services provided:

- For prenatal care for women*
- As pediatric preventive services*
- To a child who is in custody of the State*

Subrogation

The Subrogation team is involved in situations when a member is injured in an accident or event where a third party may be at fault.

All claims involving a personal injury case will be processed by Select Health, following all applicable COB rules, then sent to the State Office of Recovery Services (ORS) for subrogation to recoup any third-party liability.

* Services must be covered under the State Plan to be eligible for payment by Medicaid or Select Health.

Appendix B: Select Health Community Care-Specific Information, Continued

Restriction Program

Select Health Community Care enrollees who meet criteria may be enrolled in the Restriction Program. Members are identified for enrollment through:

- Periodic review of member profiles to identify over-utilization of medical providers, urgent care centers, specialists, medications, and/or pharmacies.
- Verbal and written reports of over-utilization use of services generated by one or more healthcare providers regarding the member. These reports are verified through a review of the member's claim history by Medicaid staff and medical consultants.
- Referral from Utah Department of Health Medicaid staff.

Enrollees in the restriction program are informed of the reasons for enrollment, counseled in the appropriate use of healthcare services, assigned a Primary Care Provider, and assigned one pharmacy for their medications. These members are required to receive their care from an assigned primary care provider or must have a referral from their primary care provider to see another physician. All pharmacy services must be received from the assigned pharmacy.

Select Health Community Care will only pay claims for services rendered by the providers listed on the card and by providers from whom the member was appropriately referred. Emergency services are not restricted to assigned providers.

Providers who are willing to see members enrolled in the restriction program are eligible to receive a care coordination payment of $120 per restricted member per month. Interested providers can contact their provider representative and ask for assistance with contracting for this payment.

The Contractor (contracted provider) maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the Contractor.

Appendix B: Select Health Community Care-Specific Information, Continued

Advance Directives

Advance directives policies and procedures and information for members include:

- Member's rights under the State (advance directives) law to make decisions concerning medical care, including the right to refuse or accept treatment
- Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive
- Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive
- Provisions for the education of staff concerning its policies and procedures on advance directives

Appendix C: Contact Information

Select Health Contact Information

Behavioral Health Preauthorization
800-876-1989

Care Management (Healthy Connections)
800-442-5305

Community Care Member Services
855-422-3234

Compliance Hot Line
800-442-4845

Customer Service
855-442-9900

Customer Service Idaho
855-442-9900

EDI/Electronic Claims
801-442-5442

Medical Preauthorization
1-800-222-6358

Medical Review/Utilization Management
801-442-5038

Member Advocates
800-515-2220

Member Services
800-538-5038

Pharmacy Services/Preauthorization
800-442-3129

Provider Relations
800-538-5054

Sales Department
801-442-5038

Intermountain Health Contact Information

Clinical Programs: intermountainhealthcare.org

Laboratory Services: 801-507-2110

Physician Relations: 801-442-2840

Visit **Medical Staff Resources** for credentialing and medical staff fees.

Appendix D: Member Rights and Responsibilities

Member Rights for Commercial and Medicare Plans

Members have the responsibility to:

- Receive information about our services, providers, and members' rights and responsibilities.
- Receive considerate, courteous care and treatment with respect for personal privacy and dignity.
- Receive accurate information regarding their rights and responsibilities and benefits in member materials and through telephone contact.
- Be informed by their provider about their health so they may make thoughtful decisions before they receive treatment.
- Candidly discuss with their healthcare provider appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. We do not have policies that restrict dialogue between provider and patient, and we do not direct providers to restrict information regarding treatment options.
- Participate with providers in decisions involving their health and the medical care they receive.
- Express concerns about Select Health and the care we provide, and receive a response in a reasonable period of time.
- Request a second opinion.
- Refuse recommended medical treatment.
- Select or change their primary care provider.
- Make recommendations regarding our members' rights and responsibilities policy.
- Have reasonable access to appropriate medical services regardless of race, religion, nationality, disability, sex, or sexual orientation, and 24-hour access to urgent and emergency care.
- Receive care provided by or be referred by their primary care provider.
- Have all medical records and other information kept confidential.
- Have all claims paid accurately and in a timely manner.

Member Responsibilities for Commercial and Medicare Plans

Members have the responsibility to:

- Treat all our providers and personnel at Select Health courteously.
- Read all plan materials carefully as soon as they enroll and ask questions when necessary.
- Ask questions and make certain they understand the explanation and instructions they are given.
- Understand the benefits of their plan and understand not all recommended medical treatment is eligible for coverage.
- Follow plans and instructions for care that have been agreed upon with the provider.

Appendix D: Member Rights and Responsibilities, Continued

- Express constructively their opinions, concerns, and complaints to the appropriate people at Select Health.
- Follow the policies and procedures of their plan, and when appropriate, seek a referral from their primary care provider to Select Health providers or call Select Health for assistance.
- Ask questions and understand the consequences of refusing medical treatment.
- Communicate openly with their healthcare provider, develop a patient-provider relationship based on trust and cooperation, and participate in developing mutually agreed-upon treatment goals.
- Read and understand their plan benefits and limitations, and call Select Health with any questions.
- Keep scheduled appointments or give adequate notice of cancellation.
- Obtain services consistently according to the policies and procedures of their plan.
- Provide all pertinent information needed by their provider to assess their condition and recommend treatment.
- Use in-network providers when applicable, carry their ID Card, and pay copay/coinsurance amounts at the time of service.

Rights and Responsibilities for CHIP and Medicaid plans*

* For members on Select Health Community Care (Medicaid) and CHIP plans, also review the information on Advance Directives on **page 63** in Appendix B.

Access Member Rights and Responsibilities documents for Medicaid and CHIP:

- **Member Rights & Responsibilities (CHIP)**
- **Member Rights & Responsibilities (Medicaid)**

Appendix E: Glossary of Terms/Acronyms

A

Accountable Care Organization (ACO): A group of managed care health plans contracted with the State of Utah to provide medical services to Medicaid members.

Action: The reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; denial or limited authorization of a requested service; or failure to provide services or act in a timely manner as required by law or contract.

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, that is recognized under State law (whether statutory or as recognized by the courts of the State) and relates to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state of Utah; the failure of Select Health to act within the time frames provided in this section; or for a resident of a rural area with only one managed care organization, the denial of a Medicaid enrollee's request to exercise his or her rights, under 42 CFR § 438.52 (b)(2)(ii), to obtain services from a nonparticipating provider.

Allowed Amount: This is the dollar amount typically considered full payment by an insurance company and an associated network of healthcare providers. It is typically a discounted rate rather than the actual charge. It is also referred to as the allowable charge, approved charge, maximum allowable, or eligible charges.

Any Willing Provider: A statutory requirement, adopted in some states, for managed care plans to accept any healthcare provider willing to meet the plan's terms and conditions. The requirement eliminates a managed care plan's screening process in developing quality- and cost-control programs.

Appeal: A written request from a member, member's personal representative, or provider for review of an action. Review by Select Health of an Adverse Benefit Determination.

Assignment of Benefits: An arrangement between the insurance company and a network provider for payment. This agreement benefits providers by guaranteeing direct payment from the insurance company rather than requiring them to seek payments from the member.

B

Benefit: The amount payable by the insurer to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy.

Benefits Package: A number of services provided by an employer to its employees after a probationary or elimination period of employment. This package could include benefits such as health insurance, life insurance, disability insurance, retirement options, reimbursement accounts, etc.

C

Claim: A form filed by a healthcare provider to an insurance company either on paper or electronically to request payment for services covered under an insured's policy.

Claim Adjustment Reason Code (CARC): Codes used to communicate an adjustment, meaning why a claim or service line was paid differently than it was billed.

Complaint: Any written or verbal communication of dissatisfaction.

Contracts: Written agreements between providers and hospitals, providers and health plans, hospitals and health plans, or all three to manage healthcare costs and charges. Healthcare providers who contract are usually placed on a network with other providers who have agreed to the same terms. Contracts also are made between health plans and an employer or between health plans and an individual.

E

Electronic Data Interchange (EDI): An electronic communication method that provides standards for exchanging data via any electronic means.

Explanation of Benefits (EOB): A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

Appendix E: Glossary of Terms/Acronyms, Continued

Explanation of Payment (EOP): Provides detail on claims that have been paid, denied or adjusted.

F

Fee-For-Service: A method of charging whereby a physician or other practitioner bills for each visit or service rendered.

Fee-For-Service Medicaid: A fee-for-service Medicaid member is defined as either: (1) a member who is not enrolled in an Accountable Care Organization (ACO); or (2) a member who is enrolled in an ACO, but the service needed is covered by Medicaid, not by the plan.

Full-billed Charges: The fee for service a provider invoices for services rendered. This generally occurs when no contract is in place with a provider to allow for a discounted rate.

Fully Insured Plans: Plans for which the employer pays a monthly premium to an insurance carrier to assume all of the risk associated with the group insurance claims of their employees.

G

Grievance: A written or verbal communication of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action.

H

Health Flexible Spending Account (FSA): An individual, tax-advantaged, self-insured medical reimbursement plan that can be funded by employee and/or employer contributions. Employee contributions can be made on a pretax basis through "cafeteria plan" salary reduction elections. It reimburses qualified medical expenses, which do not include healthcare premiums and qualified long-term care services.

Health Maintenance Organization (HMO): An organization that provides health coverage for its members at a low, fixed cost. With an HMO, members receive care provided through the HMO's network of physicians and facilities.

Health Reimbursement Account (HRA): An individual, tax-advantaged, self-insured medical reimbursement plan that is only funded by employer contributions. It reimburses qualified medical expenses, including healthcare premiums.

Health Savings Account (HSA): A portable, non-forfeitable, individual tax-advantaged account that can be funded by contributions from employee, employer, and/or anyone else. It reimburses qualified medical expenses and certain premiums, such as COBRA coverage, long-term care, coverage while on unemployment compensation, or for any health insurance after age 65 except Medicare supplemental policies. It can be used for non-medical expenses without penalty after age 65—subject only to income tax (before age 65, income tax and 10 percent excise tax are incurred).

High Deductible Health Plan (HDHP): These plans can be used with a tax-advantaged Health Savings Account (HSA). These plans carry a higher deductible, which is waived for preventive care services.

I

Indemnity: Compensation or a benefit paid by an insurance policy for insured loss.

N

Network Providers: A limited grouping or panel of providers in a managed care arrangement who are contracted with Select Health to provide service to Select Health members and who may have several delivery points. Enrollees may be required to use only network providers or may have financing liability for using nonparticipating providers for medical services.

P

Point of Service (POS): The point-of-service option is a combination of HMO and Preferred Provider Organization (PPO) features. This plan provides a comprehensive set of health benefits and offers a full range of health services much the same as the HMO. However, members do not have to choose how to receive services until they need them. The member can then opt to use the defined participating benefits or can go out of the network for services but pay the difference for nonparticipating benefits (e.g., 100% coverage for in network vs. 80% coverage for out of network).

Appendix E: Glossary of Terms/Acronyms, Continued

Preferred Provider Organization (PPO): This is a managed care arrangement consisting of a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third-party administrator, or other sponsoring group to provide healthcare services to covered persons.

Premium: The amount paid to an insurer for specific insurance protection. This is either paid by the insured, the insured's employer, or a combination of both.

R

Remittance Advice (RA): A letter sent by a customer to a supplier, to inform the supplier that their invoice has been paid.

Remittance Advice Remark Code (RARC): Provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing.

S

Self-funded Plans: These health plans, also known as self-insured plans, are ones where the employer assumes the financial risk of covering its employees and pays medical claims from its own resources. These plans are regulated by the Employee Retirement Income Security Act (ERISA). However, state laws and regulations do not apply to self-funded plans.

Small Employer: Small employers are those organizations that have two to 50 benefits eligible employees.

T

Third Party Administrator (TPA): An independent company that offers administrative services for employers or government entities. The TPA deals with billing, claim processing, and other administrative functions.

U

Urgent Pre-service Claim: Any pre-service claim that, if subject to the normal time frames for determination, could seriously jeopardize the enrollee's life, health or ability to regain maximum function or would subject the enrollee to severe pain that could not be adequately managed without the requested service.

Utilization: Patterns of usage for a single medical service or type of service, such as hospital care, prescription drugs, and physician visits. Measurement of utilization of all medical services in combination is typically done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period, such as the number of annual admissions to a hospital per 1,000 persons over age 65.

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