



# Provider Reference Manual

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SelectHealth Plans

## TABLE OF CONTENTS

1.0	Introduction.....	4
1.1	Privacy Notification.....	4
1.2	Benefits and Responsibilities of Participation.....	5
2.0	Access, Availability, and Quality Improvement.....	6
2.1	Medical Access Standards.....	6
2.2	Behavioral Health Access Standards.....	6
2.3	Monitoring Patient Access.....	7
3.0	Auto Recovery.....	8
3.1	What Does Auto Recovery Look Like?.....	8
3.2	Future Refund Requests.....	8
3.3	Payment Options and Contact Information.....	9
3.4	Impact of Multiple Internal SelectHealth Provider ID Numbers.....	9
4.0	Care Management.....	10
5.0	Claims Filing Deadlines.....	11
6.0	Claims Submission.....	12
6.1	EDI Transactions.....	12
6.2	Manual Transactions.....	12
7.0	Code of Ethics.....	13
8.0	Coordination of Benefits (COB).....	14
8.1	Definition.....	14
8.2	Order of Benefit Determination.....	14
9.0	Credentialing and Contracting Process.....	17
9.1	Credentialing.....	17
9.2	Contracting.....	17
10.0	Fraud/Waste/Abuse (FWA) Program.....	18
10.1	FWA Oversight and Protection Program.....	18
10.2	Mandatory Reporting of Fraud or Abuse.....	18
10.3	FWA Training and Attestation.....	19
11.0	Healthy Beginnings.....	20
12.0	Medical Necessity.....	21
12.1	Definition of Medical Necessity/Medically Necessary.....	21
13.0	Member Advocates.....	22
14.0	Member Appeals.....	23

Continued on page 3...

## Table of Contents, Continued

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15.0	Member Notification Upon Provider Termination from SelectHealth .....	24
16.0	Pharmacy Tools .....	25
17.0	Pre-Existing Conditions (PECs) .....	26
17.1	PEC Definitions .....	26
17.2	PEC Waiting Period .....	26
17.3	PEC Automatic Exclusions .....	28
18.0	Preauthorization .....	29
18.1	Member Responsibility for Preauthorization .....	29
18.2	Information Needed for Preauthorization .....	30
18.3	Additional Contact Information .....	30
19.0	Preventive Care* Recommendations .....	31
20.0	Provider Appeals .....	32
20.1	Filing a Formal Appeal .....	32
20.2	Understanding the Review Process .....	32
21.0	Provider Remittance Advice .....	33
22.0	Public Reporting .....	34
23.0	Quality Assurance and Operation Standards .....	35
23.1	Requirements .....	35
23.2	Record-Keeping Requirements .....	35
23.3	Office Site Visits .....	38
24.0	Subrogation .....	40
24.1	Automobile Accidents .....	40
24.2	Worker Compensation .....	40
24.3	Third Party Liability (TPL) .....	40
24.4	Medical Malpractice .....	40
25.0	Utilization Management Incentives Policy .....	41
Appendices .....		42
Appendix A: SelectHealth Medicare®-Specific Information (Medicare) .....		43
Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid) .....		61
Appendix C: Contact Information .....		68
Appendix D: Member Rights and Responsibilities .....		69
Appendix E: Glossary of Terms/Acronyms .....		70

## 1.0 Introduction

The SelectHealth 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](https://selecthealth.org/providers) website, a reference guide for education, training, and navigating SelectHealth policies and procedures for commercial and government plans.

### 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 SelectHealth 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:

- > **SelectHealth Medicare® (Medicare):** Begins on [page 41](#)
- > **SelectHealth Community Care® (Medicaid):** Begins on [page 59](#)

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. All manuals can be accessed at [selecthealth.org/providers/publications](https://selecthealth.org/providers/publications).

### Updates to SelectHealth Provider Reference Manuals

All provider reference manuals are reviewed and updated regularly as information changes in any section. The most recent version can be accessed at [selecthealth.org/providers/publications](https://selecthealth.org/providers/publications).

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

#### NOTE:

When a topic in this manual has Medicare/Medicaid plan-specific information in the appendices, you will see a reminder like the one below in the left-hand column:

**\* For members on SelectHealth Medicare Advantage plans, review the information in [Appendix A](#).**

Contact or access information related to a topic typically appears in a box either in the left-hand column or at the bottom of the page, similar to the one shown below.

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

## 1.1 Privacy Notification

Our notice of privacy practices, [Protecting Your Privacy](#), 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](mailto:privacy@imail.org), or writing to the following address:

SelectHealth  
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 SelectHealth are:

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

**Responsibilities** of SelectHealth and contracted providers include:

- > SelectHealth members being directed to facilities and other healthcare providers who participate on SelectHealth panels, whenever possible
- > Providers not billing the member for covered services provided to the member, as specified in the SelectHealth 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 SelectHealth Maximum Allowable Fees as payment in full for covered services for SelectHealth members

## 2.0 Access, Availability, and Quality Improvement

### 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 SelectHealth 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.

## 2.3 Monitoring Patient Access

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

**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 SelectHealth 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.

SelectHealth 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.** SelectHealth uses this survey to ask health plan enrollees about their experiences with behavioral health care and services.

> **Member Calls.** SelectHealth monitors calls to Member Services or the SelectHealth 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.

> Behavioral health failed access reports.

> Appointment wait-time surveys.

> Other methods as appropriate.

## 3.0 Auto Recovery

### 3.1 What Does Auto Recovery Look Like?

**NOTE:**

Access a [Sample Remittance Advice](#) and a [Remittance Advice Key](#) for more information.

### 3.2 Future Refund Requests

Automatic (Auto) Recovery is the process SelectHealth 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.

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.

All claims we adjust will be set up to auto recover from the next payment. There may be times when SelectHealth 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

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

### 3.4 Impact of Multiple Internal SelectHealth Provider ID Numbers

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

SelectHealth 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. Access a [printable version](#) of how auto recovery works and can benefit your practice.

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

SelectHealth provides Care Management services for SelectHealth members. Case Managers work closely with the Intermountain Clinical Program work groups. Members are stratified using multiple tools and a member of the care management team contacts those found to be at risk.

The following **services** are currently provided:

- > Proactive outbound call support
- > Needs assessments performed by a nurse
- > Individual member coaching
- > Educational materials mailed to the member's home
- > Referral to facility-based classes
- > Assistance with medication compliance, equipment, and supplies
- > Assistance with insurance benefit questions

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 make sure immediate and ongoing needs are met and that the best possible care is received

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

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

## 5.0 Claims Filing Deadlines

Claims submitted directly to SelectHealth for payment to a provider must be submitted to SelectHealth on UB-92/04 or HCFA 1500 claim forms within **12 months** of the date of service. Claims received by SelectHealth 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 SelectHealth is the secondary payer) will be made only if the information supporting the payment is submitted to SelectHealth 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

For more information about electronic submission, contact our EDI team:

**800-538-5099**  
[edi@selecthealth.org](mailto:edi@selecthealth.org)  
[selecthealth.org/providers/claims/edi](https://selecthealth.org/providers/claims/edi)

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 [selecthealth.org/providers/claims/edi](https://selecthealth.org/providers/claims/edi).

**NOTE:** The Electronic Remittance Advice (ERA or 835) and Electronic Funds Transfer (EFT) forms must be accessed and submitted from our Provider Portal due to the nature of information.

Learn how to accessing secure online tools by reviewing the information in the box at the bottom of this page.

### 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 SelectHealth Medicare® can be found at [cms.gov](https://cms.gov). Claims should be mailed to:

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

#### How to Access Secure Online EDI Tools

The [SelectHealth Provider Portal](#)\* requires a secure login to use online tools, such as the Provider Benefit Tool and CareAffiliate, for verifying member eligibility and tracking claims.

For new accounts, complete and submit **BOTH**:

> [Information Technology Services Agreement \(ITSA\)](#)

> [Login Application](#) - For a new user on an existing account, submit **ONLY** the Login Application (see above).

\* Access to online claims and eligibility information is available to participating providers only. Noncontracted providers can call Member Services at 800-538-5038 for benefits, eligibility, and claims information.

## 7.0 Code of 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's values of Trust, Excellence, Accountability, and Mutual Respect.

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 noncompliant 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**.

For more information, download the [Code of Ethics Booklet](#).

## 8.0 Coordination of Benefits (COB)

### 8.1 Definition

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.

#### 8.2.1 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.** The benefits of the plan that covers the person as an employee, member, subscriber, or other than as a dependent are considered primary over those that cover the same person as a dependent.
- 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.

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 plan is primary. If there is no court decree or it does

\* For members on SelectHealth Medicare Advantage plans, review the information in [Appendix A](#).

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

Order is determined as:

- 1 Subscriber over dependent
- 2 Birthday rule of parents
- 3 Longer/shorter applies when member is dependent on spouse and parents' plan

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:

- In the amount or scope of a plan's benefits
- In the entity which pays, provides, or administers the plans' benefits
- 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:**

TRICARE dental uses standard coordination guidelines.

### **8.2.2 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.

### **8.2.3 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. SelectHealth is a complying plan and coordinates benefits with non-complying plans according to the following:

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

### **8.2.4 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 active employee or spouse's plan who is an active employee



## 9.0 Credentialing and Contracting Process

### 9.1 Credentialing

Follow these steps to become a SelectHealth-contracted provider:

- 1 Send an email to [practitionercontracting@selecthealth.org](mailto:practitionercontracting@selecthealth.org) indicating your interest and requesting the Health Plans Questionnaire.
- 2 You will receive a message via Adobe including instructions of what you will need to do next.
- 3 Follow all instructions thoroughly including providing all required attachments.
- 4 You will receive the credentialing application via email.
- 5 Complete and return the credentialing application according to the instructions in the email. (**NOTE:** The process may differ slightly for facilities and vendors requesting to join the network. These requests can still be sent to the email inbox noted above).

**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.

### 9.2 Contracting

Once credentialing is complete, you will receive a contract entitled, “**SelectHealth Participating Practitioner Service Agreement (PPSA)**” or a “**SelectHealth Participating Facility Agreement**” for facilities and vendors via Adobe. The networks included in the PPSA will be SelectHealth Choice, SelectHealth Care, SelectHealth Med, SelectHealth Value, and SelectHealth 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 SelectHealth.

## 10.0 Fraud/Waste/Abuse (FWA) Program

The SelectHealth Special Investigations Unit (SIU) has the primary responsibility of investigating fraud and abuse for SelectHealth. 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 SelectHealth who have been given the mandate of ensuring that SelectHealth is in compliance with the State Mandatory Reporting Act and with SelectHealth's own policies and procedures.

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

### 10.2 Mandatory Reporting of Fraud or Abuse

SelectHealth 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 SelectHealth employees to report to their immediate supervisor, the SelectHealth Compliance Department, or the SelectHealth 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 **SelectHealth 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](mailto:commhealthybeginnings@selecthealth.org).

SelectHealth Healthy Beginnings is a program created for expectant mothers. 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:

- > Access to a high-risk perinatal nurse care manager
- > Assistance in answering questions, offering emotional support, and providing referrals to community resources, such as Women, Infants and Children (WIC)
- > Educational materials on topics, such as childbirth and breastfeeding
- > Burp cloths
- > A magnet with important information about pre-term labor and phone number

To help SelectHealth introduce Healthy Beginnings and support the expectant mother, **please fax the prenatal record from the first visit** to the correct number for the member's plan indicated below:

- > Commercial plans - **801-442-0825**
- > SelectHealth Community Care (Medicaid) - **801-442-0625**

## 12.0 Medical Necessity

\* For members on SelectHealth Medicare 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.

### 12.1 Definition of Medical Necessity/Medically Necessary

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 SelectHealth 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.

The standard definition of “Medical Necessity/Medically Necessary” is the **same for all commercial plans in 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

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 SelectHealth’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 **800-538-5038** for Commercial Plans

> **855-442-9900** for SelectHealth Medicare® (Medicare)

> **800-538-4234** for SelectHealth 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**

SelectHealth Member Advocates<sup>SM</sup> 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 SelectHealth Medicare Advantage plans, review the information in [Appendix A](#).

### 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).

### NOTE:

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

### 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 63](#)**).

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 ([Access more information](#).)
- 2 Authorize someone else (such as a provider) to do so on their behalf

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, file an appeal of any adverse benefit determination on behalf of the enrollee by completing and submitting the online [Provider Appeal Form](#).

**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:**

- **SelectHealth 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 19.0 on [page 29](#)).
- **SelectHealth 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.

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.

## 15.0 Member Notification Upon Provider Termination from SelectHealth

The following statement is included to each Participating Provider Services Agreement (PPSA) signature page for SelectHealth participating providers. It is also included in this manual as notice of this policy to all current SelectHealth 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, SelectHealth will notify, at least 15 calendar days prior to the effective date of termination, the SelectHealth members who have received care in my practice that I will no longer be a participating provider with SelectHealth. I understand that SelectHealth will assist the member in making arrangements for future medical care.”*



## 16.0 Pharmacy Tools

### SelectHealth Pharmacy Provider Reference Manual

For detailed information regarding SelectHealth Pharmacy guidelines, please see the [SelectHealth Pharmacy Provider Reference Manual](#).

### Additional Pharmacy Tools

Access additional pharmacy information, including:

- > [Pharmacy Search](https://selecthealth.rxeob.com/patientdashboard_sh/pharmacy_search.aspx): [https://selecthealth.rxeob.com/patientdashboard\\_sh/pharmacy\\_search.aspx](https://selecthealth.rxeob.com/patientdashboard_sh/pharmacy_search.aspx)
- > [Prescription Drug Lists/Formularies/Drugs with Special Requirements](https://selecthealth.org/providers/pharmacy/lists-and-formularies): <https://selecthealth.org/providers/pharmacy/lists-and-formularies>
- > [Intermountain Home Delivery](https://selecthealth.org/providers/pharmacy/home-delivery): <https://selecthealth.org/providers/pharmacy/home-delivery>
- > [Pharmacy & Therapeutics newsletter](https://selecthealth.org/providers/resources/publications/pharmacy-and-therapeutics-archive): <https://selecthealth.org/providers/resources/publications/pharmacy-and-therapeutics-archive>
- > [Medication Therapy Management \(MTM\) Program \(SelectHealth Medicare®\)](https://selecthealth.org/providers/pharmacy/mtm): <https://selecthealth.org/providers/pharmacy/mtm>
- > [Opioid Prescribing Resources](https://selecthealth.org/providers/pharmacy/opioid-prescribing): <https://selecthealth.org/providers/pharmacy/opioid-prescribing>

## 17.0 Pre-Existing Conditions (PECs)

### 17.1 PEC Definitions

A PEC is defined based on the state transition plan that applies. (See section 17.2 below for more information on transition plans.)

#### UTAH Transition Definition

A condition or symptom is considered “pre-existing” if occurring in the two-year period preceding the effective date of coverage:

- 1 Which would cause an ordinarily prudent person to seek diagnosis, care, or treatment
- 2 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 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.

### 17.3 PEC Waiting Period

The PEC waiting period is not waived, regardless if the member had prior coverage during the transition period; however, the transition plan may be considered creditable coverage toward future insurance policies if the future insurance carrier chooses.

New members to a health insurance plan may be placed in a “Pre-Existing Wait Period.” All or part of this wait period may be waived for non-transition plans with proof of prior insurance, depending on the elapsed time between the end of the old policy and the date the new policy starts. This time is

**NOTE:**

See Section 17.3.3 below for more information.

referred to as the “coverage gap,” which must be 63 days or less between insurance carriers, including between the current and prior plan.

### **17.3.1 Elimination of PEC Waiting Periods and Exclusions**

The Affordable Care Act (ACA) mandates insurers/employer groups may not impose PEC Waiting Periods or PEC exclusions on ACA plans.

Pre-existing conditions (or conditions determined as PEC) are not covered while a member is in a pre-existing waiting period.

### **17.3.2 Plans Not Subject to the Elimination Provision of the ACA**

The period may be waived if proof of prior coverage is obtained.

The Health Insurance Portability and Accountability Act (HIPAA) regulations do not require insurance carriers to send a Certificate of Creditable Coverage (CCC) and a Verification of Coverage letter to members; however, the SelectHealth sends the letter(s) upon the plan’s termination. This automatically generated letter includes the dates the member’s coverage with SelectHealth began and ended

### **17.3.3 Creditable Coverage Certificate (CCC)**

Insurance carriers provide certificates to their members as proof of prior insurance coverage whenever a plan is terminated. With this proof, members may have all or part of the PEC wait period removed if there is no more than a 63-day gap between insurance carriers.

SelectHealth attempts to obtain CCC information by:

- > Sending PEC letters at the time of enrollment to advise members of their PEC status. The letter has the PEC Wait Period dates listed and requests and explains the purpose of the certificate of creditable coverage.
- > Including PEC information in new enrollment packets and on the website for members to reference.
- > Educating insurance brokers so that they can better explain PEC and the steps required to waive it to new members.
- > Requesting prior and/or other coverage information on the new enrollment application.

### 17.3 PEC Automatic Exclusions

There are some diagnoses and procedures that are automatically excluded from coverage while a member is in a pre-existing wait period

In addition to the standard limitations and exclusions noted above, unless determined by SelectHealth to be a medically necessary emergency, the following are excluded from transition plans:

**Services Provided for (UTAH ONLY):**

- > Amenorrhea
- > Congenital deformities
- > Cystocele
- > Dysmenorrhea
- > Enterocoele
- > Sleep problems/disorders
- > Urethrocele
- > Uterine prolapse

**Procedures (UTAH ONLY):**

- > Bunionectomy
- > Carpal tunnel surgery
- > Hysterectomy (except in cases of malignancy)
- > Joint replacement
- > Mammoplasty, reduction
- > Morton's neuroma, surgical treatment
- > Myringotomy/tympanotomy (with or without tubes insertion)
- > Nasal septal repair, except injuries after effective date of coverage
- > Retained hardware removal
- > Tonsillectomy/adenoidectomy

## 18.0 Preauthorization

\* For members on SelectHealth Medicare Advantage plans, review the information in [Appendix A](#).

**Questions?** Call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**.

### 18.1 Member Responsibility for Preauthorization

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

- > [CareAffiliate](#)<sup>®</sup>, which offers more efficient and sometimes auto-approval of preauthorization requests
- > [AIM](#)<sup>®</sup> [Specialty Services](#), which is our resource for clinical appropriateness and preauthorization review of genetic testing, radiation oncology, and medical oncology.
- > [PromptPA](#), which is our online preauthorization tool 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, SelectHealth Medicare, and SelectHealth Community Care.

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 SelectHealth at least 14 days in advance of services.

It is the responsibility of SelectHealth 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. SelectHealth 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.

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 (SelectHealth Choice<sup>®</sup>, SelectHealth Med Plus<sup>®</sup>, and SelectHealth Care Plus<sup>®</sup>) are responsible to complete preauthorization for certain services from non-participating providers.

## 18.2 Information Needed for Preauthorization

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 14-day period 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

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

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

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

SelectHealth 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 SelectHealth Medicare Advantage plans, review the information in [Appendix A](#).

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

Intermountain Healthcare® and SelectHealth use preventive care recommendations 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.

The recommendations are a combination of national preventive care guidelines that have been reviewed and approved by the Intermountain Medical Group® leadership and by the SelectHealth Quality Improvement committee.

The recommendations cover the routine care of adults and include statements regarding patient counseling, preventive chemoprophylaxis, immunizations, and basic screening exams, as well as some specific recommendations for high-risk groups. Recommendations for individuals with signs and symptoms are not included. 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.

**Note:** Tracking forms can assist providers in identifying services that have been performed or should be addressed.

While preventive care is a partnership between the patient and his or her provider and the healthcare system, the patient is primarily responsible for his or her 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.

Access current Utah and Idaho preventive care recommendations for:

- > [Children](#)
- > [Adolescents](#)
- > [Adults](#)

## 20.0 Provider Appeals

### 20.1 Filing a Formal Appeal

The SelectHealth Provider Appeals process addresses disputes that arise between a healthcare provider and SelectHealth. 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 SelectHealth Provider Relations representative.

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 (see below).
- 3 Mail or fax the completed form to SelectHealth within **180 days (for Commercial and Medicare) or 90 days (for Medicaid)** from the date the claim was processed to:

SelectHealth Provider Appeals  
P.O. Box 30192  
Salt Lake City, UT 84130-0192  
Fax: 801-442-6708

- 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 SelectHealth; 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 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



# SelectHealth Remittance Advice Key

**selecthealth.**  
 P.O. BOX 30192  
 SALT LAKE CITY, UT 84130  
 PO BOX 1149

**EXPLANATION OF PAYMENT**

NAME	A DOCTOR		
STATEMENT DATE	06/30/2011	PAGE	1 of 1
TEL NUMBER	123456789		
PROVIDER ID	1070000001		
REFERENCE ID	2011063011111111		
CHECK NUMBER	0	AMOUNT	0.00

PATIENT NAME: JONEL TEST A  
 SUBSCRIBER NAME: JONEL TEST B  
 PROVIDER NAME: DOCTOR A

PATIENT ID: 800012345-01  
 CLAIM ID: 090000123400  
 PRODUCT: Select Care Plus

PATIENT A/C# 22251156-6

DATE OF SERVICE	SERVICE CODE	FEES CHARGE	ALLOWED AMOUNT	PLAN PAID	ADJUSTMENT	GC	CARC	RARC	ADJUSTMENT	GC	CARC	RARC
05/06/11 to 05/06/11	92004	177.00	143.62	158.62	33.98	CO	45		35.00	PR	3	
05/06/11 to 05/06/11	9701930F	1525.00	1194.36	779.69	324.64	CO	45		225.00	PR	06	1083
05/06/11 to 05/06/11	922000000RT	100.00	0.00	0.00	100.00	CO	45	1085				
<b>TOTAL:</b>		<b>1902.00</b>	<b>1341.98</b>	<b>857.31</b>	<b>TOTAL CO:</b>	<b>440.02</b>			<b>TOTAL PR:</b>	<b>454.67</b>		
<b>INTEREST:</b>					<b>TOTAL OA:</b>	<b>0.00</b>			<b>TOTAL PI:</b>	<b>0.00</b>		

PATIENT NAME: THOMAS TEST  
 SUBSCRIBER NAME: THOMAS TEST B  
 PROVIDER NAME: DOCTOR A

PATIENT ID: 800012347-01  
 CLAIM ID: 090000017002  
 PRODUCT: Select Health Plus

PATIENT A/C# 124 102995170

DATE OF SERVICE	SERVICE CODE	FEES CHARGE	ALLOWED AMOUNT	PLAN PAID	ADJUSTMENT	GC	CARC	RARC	ADJUSTMENT	GC	CARC	RARC
05/10/11 to 05/10/11	90413	270.00	182.00	147.75	94.00	CO	45		34.25	PR	06	103
05/10/11 to 05/10/11	A4216	12.00	6.00	4.86	6.00	CO	45		1.14	PR	06	103
<b>TOTAL:</b>		<b>288.00</b>	<b>188.00</b>	<b>152.61</b>	<b>TOTAL CO:</b>	<b>100.00</b>			<b>TOTAL PR:</b>	<b>35.39</b>		
<b>INTEREST:</b>					<b>TOTAL OA:</b>	<b>0.00</b>			<b>TOTAL PI:</b>	<b>0.00</b>		

FEES CHARGE	ALLOWED AMOUNT	CONTRACTUAL OBLIGATION	PATIENT RESPONSIBILITY	OTHER ADJUSTMENTS	PLAN PAID	INTEREST
<b>PAYMENTS:</b>	1902.00	1341.98	460.02	454.67	857.31	1.28
<b>RECOVERIES:</b>					84.47	2.32
<b>TOTAL:</b>					<b>84</b>	<b>84</b>

**RECOVERY AND FORWARD BALANCE DETAIL FOR THIS PAYMENT**

PATIENT NAME	DATE OF SERVICE	PATIENT A/C#	CLAIM ID	ORIGINAL REFERENCE ID	RECOVERY AMOUNT	RECOVERED INTEREST	FORWARD BALANCE
RECOVERY - PREVIOUS	06/10/11	060001317000	090000010000	1234567890123456	28.25	0.00	0.00
RECOVERY - PREVIOUS	06/10/11	111111111111	090000000000	9876543210000000	854.24	0.00	34.00
THOMAS TEST A	06/10/11	124 102995170	090000017002	1234567890123456	0.00	0.00	154.54

**CLAIM ADJUSTMENT (CARC) AND REMITTANCE ADVICE (RARC) CODE EXPLANATIONS**

- 3 Coinsurance Amount
- 3 Copayment Amount
- 45 Charge exceeds fee schedule/maximum deductible or contracted/legislated fee arrangement
- 99 Non-covered charges. At least one Remark Code must be provided
- 1033 Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions
- 1085 The procedure code is not payable. It is for reporting information purposes only.
- 1089 Services deemed cosmetic are not covered.

Group Codes (GC) = CO: Contractual Obligations PR: Patient Responsibility PI: Payer Initiated Reductions OA: Other Adjustments  
 Forward Balance = Remaining recovery amount where no recovery or only a partial recovery was made for a claim on this remittance advice.

Reversal claim information will appear as negative dollars in the body of the RA. The recovery status of the claim will appear in the Recovery and Forward Balance Detail at the end of the RA.

A new claim will be processed to correct the mistake, and the new claim will list the reason for the correction.

Remember that only those claims where an actual recovery or reversal occurred on the current payment will appear in this section. Reversed or Pending Recovery claims with a remaining forward balance will not appear again until dollars are actually recovered.

This is a key to the current group codes — two-letter codes used to indicate the type of adjustment being made to the claim line and to assist providers in determining who is liable for the adjusted dollars.

Group Codes (GCs), Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) are the HIPAA-approved codes used to report dollars not paid to the provider for a particular claim.

This is a key to the CARCs, which communicate why a claim or service line was paid differently than it was billed. If no adjustment to a claim/line, then there is no adjustment reason code.


Common examples include:

- Deductible Amount
- Coinsurance Amount
- Co-payment Amount
- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

In some cases an RARC will be supplied to further define the adjustment. Since the RARC is a supplemental code to the CARC, an RARC will never be reported without a CARC.

Questions? Please contact Member Services at 800-538-5038.

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## 22.0 Public Reporting

SelectHealth publicly reports clinical quality and patient satisfaction data. Providers should contact the Intermountain Office of Patient Experience for details regarding their patient experience data.

Providers' clinical quality data is available to view on the SelectHealth provider search page or a more detailed report is available through the [intermountainphysician.org](http://intermountainphysician.org) reports page. To access that detailed information:

- 1 Log in to access secure content at [intermountainphysician.org](http://intermountainphysician.org).
- 2 Click on the "A to Z Index" button, and search for "Reports."
- 3 Under the "Physician" tab, open the "SelectHealth" folder, and click on the "SelectHealth Quality Transparency Reporting Project Report (Provider)."
- 4 Once the report appears on the right-hand side of the screen, click on "Add to My Reports." This will add the report to your "My Reports" tab to make it easier to find in the future.
- 5 Then, click "View Report," and enter your login credentials again to view your information.

## 23.0 Quality Assurance and Operation Standards

### 23.1 Requirements

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

- 1 Comply with the SelectHealth Quality Assurance Program in all respects, including, but not limited to participating in the SelectHealth member grievance and appeal processes and procedures.
- 2 Comply with the SelectHealth Utilization Management Program, including, but not limited to providing Prenotification or Precertification, when required by SelectHealth, 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 SelectHealth to provide such services to members.
- 4 Cooperate with credentialing process undertaken by SelectHealth and to cooperate with plans in meeting National Committee for Quality Assurance (NCQA) accreditation requirements.

Upon request, **SelectHealth 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.

### 23.2 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 SelectHealth 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 SelectHealth 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 SelectHealth, without charge, copies of all records reasonably needed to substantiate claims for payment for facility services.

**SelectHealth 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

SelectHealth monitors the consistency and completeness of medical record documentation as part of an effort to ensure quality patient care. The SelectHealth 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.	<p>Medication allergies/adverse reactions should be prominently noted (in an easily recognizable location) on the record.</p> <p>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.</p> <p>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).</p>
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.	<p>All records, reports, consultations, summaries, etc. will be secured within the record/folder.</p> <p>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.</p> <p>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.</p>
Confidentiality.	<p>All medical records should comply with the provider office confidentiality policy and in accordance with the SelectHealth Participating Provider Service Agreement and applicable laws and regulations, such as HIPAA.</p> <p>Providers shall have a policy and/or procedure regarding the release of patient information.</p> <p>The provider shall afford patients the opportunity to approve or refuse the release of identifiable personal information or organization, except when required by law.</p>
Consultants, Labs, and Imaging Reports Initialed by Provider.	<p>Consultation, labs, and imaging reports filed in the chart should have the provider initials to signify review.</p> <p>If the reports are presented electronically or by some other method, there is also representation of ordering provider review.</p> <p>Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.</p>

**Figure 2. Provider Office Medical Record Standards, Continued**

Continuity of Care.	If a consult is requested, a note/letter from the consultant should be included in the record.
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 SelectHealth 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.

## 23.3 Office Site Visits

An office site visit will be conducted by a SelectHealth 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 SelectHealth 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 SelectHealth 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 SelectHealth 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 SelectHealth. 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
<b>Accessibility &amp; Appearance</b>	<p>Ability to accommodate the disabled in compliance with state and federal standards (e.g., Americans with Disabilities Act [ADA], handicapped parking, and access)</p> <p>Clean, well-lit, office that provides adequate seating for patients to feel comfortable receiving care</p>	<p>A reception area that permits a receptionist to observe the waiting room</p> <p>Adequate parking to handle the expected patient volume</p>
<b>Safety</b>	<p>Fire extinguisher(s) that is (are) routinely checked by recognized agency according to local ordinances</p> <p>Building that meets local fire/safety code for smoke alarms</p>	<p>Visible exit signs, evacuation plan, and posted evacuation routes</p> <p>Clear and unobstructed passageways</p>
<b>Provider Availability</b>	<p>24-hour service for emergent and/or urgent situations for all members*</p> <p>A method to schedule emergency and urgent visits within the routine office schedule for minimizing unexpectedly long waiting times for previously scheduled patients</p>	<p><b>Methods to:</b></p> <ul style="list-style-type: none"> <li>• Monitor and compare the number of patients served per hour versus scheduled per hour.</li> <li>• Schedule extra time for visits that take longer than routine visits (e.g., physical examination, a patient with complicated health issues, special procedures).</li> </ul>
<b>Emergency Preparedness</b>	<p>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)</p> <p>Posted emergency telephone numbers (e.g., for ambulance, hospital, poison control, and/or 911)</p>	<p><b>Emergency resuscitation cart present:</b> Maintain procedures for routinely checking the cart for pharmaceutical and sterilized equipment expiration dates and nonfunctional equipment (e.g., dead batteries in the laryngoscope).</p> <p><b>Defibrillator present:</b> Office staff provides education and training on proper equipment maintenance and operation.</p>
<b>Medications</b>	<p>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.</p> <p>Prescription pads that are inaccessible to patients.</p>	<p>Process for dating and rotating stock medications</p> <p>Routine monitoring of drug stock expiration dates</p> <p>Disposal process for expired medications in accordance with applicable hazardous waste laws</p> <p>Storage for controlled substances and medications in accordance with state and federal laws</p>
<b>Infection Control</b>	<p>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)</p>	<p>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</p>

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

## 24.0 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.

### 24.1 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, SelectHealth is reimbursed for claims paid.

### 24.2 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, SelectHealth becomes primary and processes claims according to benefits. When a provider receives duplicate payment from both SelectHealth and a workers compensation carrier, they should call SelectHealth and request our payment be taken back.

### 24.3 Third Party Liability (TPL)

This category covers most accidental injuries not listed above. Including, but not limited to, injuries in a public place, injuries which occur in a home, slip & fall injuries, hit by an object, church ball games, etc. These claims are usually paid by SelectHealth. Subrogation researches each case to determine if another party should pay, in which case, SelectHealth would eventually be reimbursed for any claims paid. Some possible payers would be homeowners insurance or property insurance.

### 24.4 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. SelectHealth 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.



## 25.0 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 SelectHealth policy addresses financial incentives related to utilization and utilization management (UM) decisions:

- 1 UM decision-making by SelectHealth employees is to be based on the appropriateness of care and service and the existence of coverage.
- 2 SelectHealth 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 SelectHealth does not provide financial incentives for UM personnel that encourage decisions that result in under-utilization of services otherwise needed by members.

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

## Appendices

<b>Appendix A:</b> SelectHealth Medicare®-Specific Information (Medicare) .....	43
<b>Appendix B:</b> SelectHealth Community Care®-Specific Information (Utah Medicaid) .....	61
<b>Appendix C:</b> Contact Information .....	68
<b>Appendix D:</b> Member Rights and Responsibilities .....	69
<b>Appendix E:</b> Glossary of Terms/Acronyms .....	70

## Appendix A: SelectHealth Medicare™-Specific Information

### Introduction

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

Physicians and other healthcare professionals who participate on SelectHealth 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 SelectHealth [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. SelectHealth Medicare Online Resources**

### SelectHealth Medicare™

SelectHealth Medicare plans for Medicare Advantage beneficiaries are available to residents in Utah, Idaho, and Nevada based on the coverage map below.

Physicians and other healthcare professionals who participate on SelectHealth 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 Advantage marketing by providers, and STAR ratings.

Effective **July 1, 2022**, SelectHealth expanded its Utah Medicare network to include University of Utah hospitals, clinics, and providers. [Learn more.](#)

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## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Order of Benefit Determination: Plans that include Medicare

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 SelectHealth and obtains only Medicare Part A, Part B, or neither, SelectHealth will reduce the benefits by the amount Medicare would have paid (e.g., 80% of the billed amount or SelectHealth-eligible charges, whichever is less), where Medicare is prime for these groups.

#### Dependents

Where Medicare is prime for the subscriber, SelectHealth 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.

Medicare coverage does not include prescription benefits; therefore SelectHealth's prescription benefit applies.

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 SelectHealth coordinates benefits as usual.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Dual Entitlement

\* 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.

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:

- 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

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

- 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**

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### 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

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.

#### 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.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Other Party Liability

#### Coordination of Benefits

**NOTE:**

SelectHealth Medicare will be the primary insurance carrier over individual and inactive group plans.

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.

Beneficiaries must be eligible for Original Medicare parts A and B to elect coverage with a SelectHealth Medicare plan. SelectHealth 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 SelectHealth Medicare® plans coordinate benefits with group health insurance policies:

#### 1 SelectHealth Medicare Working Aged

- Active employer group insurance plans are primary to SelectHealth Medicare if the group has **20 or more** employees.
- Active employer group insurance plans are secondary to SelectHealth Medicare if the group has **less than 20** employees.

#### 2 SelectHealth Medicare Disability

- Active employer group insurance plans are primary to a SelectHealth Medicare if the group has 100 or more employees.
- Active employer group insurance plans are secondary to SelectHealth Medicare if the group has 99 or fewer employees.

#### 3 SelectHealth 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 SelectHealth Medicare. After the coordination period, SelectHealth Medicare will become the primary insurance policy.

#### Auto, Workers’ Compensation, and Other Liability Insurance

SelectHealth 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). SelectHealth 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.

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 SelectHealth Medicare during any settlement negotiations.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Hospice

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

### Medicare-Approved Clinical Trials

Original Medicare is responsible for the primary payment of approved clinical trials. SelectHealth 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 SelectHealth, 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: SelectHealth Medicare™-Specific Information, Continued

### Medical Necessity and Prior Authorization

#### Questions?

Call SelectHealth 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 SelectHealth 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 SelectHealth 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

SelectHealth Medicare requires the Request for Preauthorization (RPA) form for all preauthorization requests for all SelectHealth members. This includes commercial products, SelectHealth Medicare, and SelectHealth 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 SelectHealth alone does not qualify as completion of the preauthorization process.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Time Frames for Organization Determinations

An enrollee or any physician may request that SelectHealth 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 SelectHealth 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, SelectHealth may extend this time frame by **45 days**.

### Responsibilities of the Requesting Provider

The requesting provider must:

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

Fax: **877-228-0517**

Phone: **800-442-5305**

U.S. Mail: Attention: Health Services, SelectHealth  
VCT 5th Floor, 5381 Green Street  
Murray, UT 84123

Email/Scan: [benefit.determination@selecthealth.org](mailto:benefit.determination@selecthealth.org)

### Forms and Criteria

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

The SelectHealth Request for the Preauthorization Form must be completed by the provider.

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: SelectHealth Medicare™-Specific Information, Continued

**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

SelectHealth 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. SelectHealth will require the provider to accept payment from SelectHealth as payment in full or bill the Department or Medicaid plan for the cost share portion and accept as payment in full.

SelectHealth, 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.

SelectHealth 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, an appeal for further review of the request can be filed.

Providers must 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 **800-538-5038**.

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: SelectHealth Medicare™-Specific Information, Continued

### Member Appeals and Grievances

#### Filing an Appeal

Questions about the appeals process? Call Appeals and Grievances at **800-538-5038**.

#### Pre-Service Level 1 Appeals

If we make a coverage decision and a SelectHealth Medicare® member is not satisfied with the decision, he or she 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.

As a SelectHealth 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 [SelectHealth 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 appeal to [appeals@imail.org](mailto:appeals@imail.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. Initiate the appeal by calling Appeals and Grievances at **800-538-5038**.

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

For expedited appeals, we will make our determination **within 72 hours** from the time 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 we decide to take extra days to make the determination, we will notify you and the enrollee in writing.

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).

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Standard Appeals (Part C only)

**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.

**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.

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:

SelectHealth Medicare                      Fax: **801-442-0762**  
P.O. Box 30196  
Salt Lake City, UT 84130-0196

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.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

**If the review organization says yes to part or all of the appeal,** SelectHealth 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 SelectHealth.

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

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.

### 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 his or her 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: SelectHealth Medicare™-Specific Information, Continued

### Medicare Preventive Benefits

Coverage of preventive services for SelectHealth 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 Advantage 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. SelectHealth® will send an HRA to every SelectHealth Medicare enrollee when they sign up for the plan. When the enrollee returns the HRA to SelectHealth, the form will be sent to the primary care physician's office so that it is available for providers.

#### Combination Visits for SelectHealth Advantage Members

**Figure 6** below presents code combinations for identifying services rendered for the comprehensive exam.

To encourage members to receive an annual comprehensive medical exam, SelectHealth 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. Code Combinations for Comprehensive Exam**

AWV plus:	Code Combination (1 and 2)	Modifier/Notes
Preventive Exam, Initial Visit	<ol style="list-style-type: none"> <li><b>G0438</b> Annual Wellness Visit, including a personalized prevention plan of service, initial visit</li> <li><b>99387</b> Initial comprehensive preventive medicine evaluation and management 65 years and older</li> </ol>	No modifier needed
Preventive Exam, Subsequent Visit	<ol style="list-style-type: none"> <li><b>G0439</b> Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit</li> <li><b>99387</b> Initial comprehensive preventive medicine evaluation and management 65 years and older</li> </ol>	
E&M, Initial Visit*	<ol style="list-style-type: none"> <li><b>G0438</b> Annual Wellness Visit, including a personalized prevention plan of service, initial visit</li> <li><b>99201-99205</b> Office visit for evaluation and management of a new patient, minor high severity</li> </ol>	A modifier 25 must be added to <b>99201-99205</b> procedure codes.
E&M, Subsequent Visit*	<ol style="list-style-type: none"> <li><b>G0438</b> Annual Wellness Visit, including a personalized prevention plan of service, initial visit</li> <li><b>99211-99215</b> Office visit for evaluation and management of an established patient, minimal to high severity</li> </ol>	A modifier 25 must be added to <b>99211-99215</b> procedure codes.

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

## Appendix A: SelectHealth 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 SelectHealth 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 FOBT
- Hypertension control less than 140/90
- Diabetes blood sugar control, eye exams and nephropathy monitoring



## Appendix A: SelectHealth 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. It 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**.

SelectHealth 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.

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](#).

## Appendix A: SelectHealth 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.

## Appendix A: SelectHealth Medicare™-Specific Information, Continued

### Documentation and Coding Tips

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](mailto:provider.development@selecthealth.org) to learn more.

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 diagnosis—each condition must be Monitored, Evaluated, Assessed, or Treated:
    - **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: SelectHealth 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**

SelectHealth 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 The Centers for Medicare and Medicaid Services (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. Please note that:

- > You will need to bill 50 modifiers instead of LT/RT as outlined by CMS.
- > SelectHealth 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:

- > Endoscopic discounting
- > Diagnostic imaging discounting
- > Therapy service discounting
- > Surgical discounting
- > Cardiovascular discounting
- > Ophthalmology discounting

## Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid)

### Questions?

Contact SelectHealth Community Care Member Services at **800-538-4234**.

Physicians and other healthcare professionals who participate on SelectHealth Community Care (Medicaid) access information on these topics on the SelectHealth [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. SelectHealth Community Care Online Resources**

# SelectHealth Community Care®

SelectHealth administers a managed Medicaid plan, SelectHealth Community Care, that is available to eligible members living in all Utah counties. Utah's Medicaid program is designed to provide valuable medical coverage for Utah residents with limited incomes and/or resources.

Learn more. Access the [SelectHealth Community Care Provider Summary](#)

## Becoming a SelectHealth Community Care Network Provider

The SelectHealth Community Care network is the contracted network for members on Utah Medicaid. NOTE: Providers must be enrolled in one of the following categories with Utah Medicaid to be a network provider:

- "Formal enrollment" allows providers to bill Utah Medicaid for fee-for-service members.
- "Limited enrollment" is for providers who prescribe but are not reimbursed by the state. This level of enrollment is appropriate for managed care providers who only bill directly to Medicaid managed care health plans, such as SelectHealth Community Care.

Learn more about joining this network:

- Download the Provider Reference Manual and review the Credentialing Policy and Procedure section.
- Contact Provider Development at 800-538-5038.

## Care Management Support

**Restriction Program:** The SelectHealth Community Care Restriction Team can help care manage patients who overutilize prescribers, providers, the ER, or pharmacies. Access the [2020 Restriction Program Practice Guideline](#). Send referrals to [MedicaidUMintake@imail.org](mailto:MedicaidUMintake@imail.org), or call 801-442-5303, option 2. Cultural Competency and Language Services: [Learn more about training and services available for your patients.](#)

## Additional Resources

- [High-Risk Reward Program: Frequently Asked Questions](#)
- [Medicaid Expansion & Integration: Frequently Asked Questions](#)
- [Utah Mental Health & Substance Use Disorder Services \(Coverage by County\)](#)
- [ADA Information: Medical Diagnostic Equipment](#)
- [Care Management Resources](#)
- [Medicaid.utah.gov](#)
- [SelectHealth Behavioral Health Resources](#)

## Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid), Continued Medicaid Preauthorization and InterQual

### Time Frames for Preauthorization

SelectHealth Community Care requires the Request for Preauthorization (RPA) form for all preauthorization requests for all SelectHealth members. This includes commercial products, SelectHealth Medicare, and SelectHealth 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 SelectHealth alone does not qualify as completion of the preauthorization process.

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, SelectHealth may extend this time frame by 14 days.

### Responsibility of the Requesting Provider

The requesting provider must:

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

Fax: **877-228-0825**

Phone: **800-442-5305**

U.S. Mail: Attention: Health Services

SelectHealth

VCT 5th Floor

5381 Green Street

Murray, UT 84123

Email/Scan: [benefit.determination@selecthealth.org](mailto:benefit.determination@selecthealth.org)

### Forms and Criteria

The SelectHealth Request for the Preauthorization Form must be completed by the provider.

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

**InterQual.** When Utah Medicaid does not have a coverage policy, InterQual criteria will be used. If InterQual criteria is not available, SelectHealth medical necessity policy will be applied.

## Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid), 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

SelectHealth 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 RA may still show contractual obligation but balance billing may be appropriate.

### Denial and Appeals

If a request for preauthorization is denied, an 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 **800-538-5038**.

When a medical record review confirms that a service requiring preauthorization did not undergo review for one 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: SelectHealth Community Care®-Specific Information (Utah Medicaid), 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 SelectHealth Pharmacy Help Desk at **801-442-4912** (Salt Lake area) or **800-442-3129**.

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

SelectHealth 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: SelectHealth Community Care®-Specific Information (Utah Medicaid), 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 SelectHealth Community Care, the Medicaid program is usually the payer of last resort, meaning all other payers are considered before Medicaid. SelectHealth is the primary payer for exceptions related to services provided:

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

- > 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 SelectHealth, following all applicable COB rules, then sent to the State Office of Recovery Services (ORS) for subrogation to recoup any third party liability.

## Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid), Continued

### Restriction Program

SelectHealth Community Care enrollees who meet criteria may be enrolled in the Restriction Program. Enrollees 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 health care services, assigned a Primary Care Provider, and assigned one pharmacy for their medications. These clients 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.

SelectHealth 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 that are in the restriction program are eligible to receive a care coordination payment of \$120 per restricted member per month. Interested providers can reach out to their provider representative and ask for assistance in being contracted for this payment.

## Appendix B: SelectHealth Community Care®-Specific Information (Utah Medicaid), Continued

### Advance Directives

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.

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

### SelectHealth Contact Information

#### Behavioral Health Preauthorization

801-442-1989

800-876-1989

#### Care Management

801-442-5305

800-442-5305

#### Community Care Member Services

801-442-3234

855-422-3234

#### Compliance Hot Line

800-442-4845

#### Customer Service

801-442-9900

855-442-9900

#### Customer Service Idaho

208-429-9900

855-442-9900

#### EDI/Electronic Claims

801-442-5442

#### Medical Preauthorization

801-442-5038

800-538-5038

#### Medical Review/Utilization Management

801-442-5038

#### Member Advocates

801-442-4993

800-515-2220

#### Member Services

801-442-5038

800-538-5038

#### Pharmacy Services/Preauthorization

801-442-4912

800-442-3129

#### Provider Relations

801-442-3692

800-538-5054

#### Sales Department

801-442-5038

### Intermountain Healthcare Contact Information

**Clinical Programs:** [intermountainhealthcare.org](https://www.intermountainhealthcare.org)

**Laboratory Services:** 801-507-2110

**Medical Staff Services:** 801-442-3123

**Physician Relations:** 801-442-2840

## Appendix D: Member Rights and Responsibilities

### Member Rights

- > Have information presented to you in a way that you will understand, including help with language needs, visual needs, and hearing needs
- > Be treated fairly and with respect
- > Have your health information kept private
- > Receive information on all treatment options
- > Make decisions about your health care, including agreeing to treatment
- > Take part in decisions about your medical care, including refusing service
- > Ask for and receive a copy of your medical record
- > Have your medical record corrected if needed
- > Receive medical care regardless of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability
- > Obtain information about grievances, appeals, and hearing requests
- > Ask for more information about our plan structure and operations
- > Get emergency and Urgent Care 24 hours a day, seven days a week
- > Not feel controlled or forced into making medical decisions
- > Ask how we pay your providers
- > Create an Advance Directive that tells doctors what kind of treatment you do and do not want in case you become too sick to make your own decisions
- > Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation. This means you cannot be held against your will. You cannot be forced to do something you do not want to do.
- > Use your rights at any time and not be treated badly if you do.
- > To be given health care services that are the right kind of services based on your needs.
- > To get health care services that are close to where you live
- > To be furnished health care services in accordance with §§ 438.206 through 438.210.

\* For members on SelectHealth Community Care (Medicaid) and CHIP plans, review the information on Advance Directives on [page 65 in Appendix B](#).

### Member Responsibilities

- > To follow the rules of your plan
- > Read your Member Handbook
- > Show your State Medicaid ID card each time you receive medical care
- > Cancel doctor appointments 24 hours ahead of time if needed
- > Respect the staff and property at your provider's office
- > Use doctors and hospitals in the [plan Name] network
- > Pay your copayments (copay)

## 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 SelectHealth 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 SelectHealth 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.

## Appendix E: Glossary of Terms/Acronyms, continued

### 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.

**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, nonforfeitable, 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 nonmedical 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 SelectHealth to provide service to SelectHealth 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.

## Appendix E: Glossary of Terms/Acronyms, continued

### 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).

**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 Preservice Claim:** Any preservice 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.