Superior Select Health Plans

2019

Superior Select Medicare Advantage Plans Provider Manual

Select (HMO-POS SNP)
A Superior Select Health Plan

Tribute (HMO-POS SNP)
A Superior Select Health Plan

Table of Contents

Contents

Section 1: Welcome to Superior Select

Founded in 2014, Superior Select coordinates health care services through a vast network designed to meet the health care needs of the diverse populations we serve. Superior Select is a local not-for-profit company, enabling us to maintain a pulse on the ever-changing landscape of local healthcare. We stay informed and view these changes as opportunities to forge new partnerships, collaborate, drive change and affect the future, all for the betterment of our members.

Superior Select provides health insurance coverage through *Arkansas Superior Select Health Plan – a Health Maintenance Organization (HMO) Special Needs Plan (SNP) with a Medicare contract and a coordination of benefits agreement with the Arkansas State Department of Health.*

Purpose of this Manual

This Manual is intended for providers who have contracted with Superior Select to deliver quality health care services to members enrolled in Superior Select Plan (HMO-SNP) Plan.

This Manual serves as a guide to providers and their staff to comply with the policies and procedures governing the administration of Superior Select's Medicare Advantage Government Programs and is an extension of and supplements the provider participation contract entered into with Superior Select (Agreement). This Provider Manual is available on Superior Select's website at **www.superiorselectMedicare.com** . A paper copy is available at no charge to providers upon request.

In accordance with the Agreement, participating Medicare providers must abide by all applicable provisions of this Manual, as may be modified from time to time upon notice. Superior Select may change this Manual to reflect changes in its policies and procedures and all revisions shall become binding 30 days after Superior Select's notice to providers, or such lesser time for Superior Select's compliance with laws, government payor contracts, or accreditation requirements.

Superior Select will notify providers of changes to this Manual in the form of Provider Bulletins or Manual updates, which shall be provided by mail, email, or other electronic means.

Superior Select Medicare Advantage

As a Medicare Advantage managed care organization, coverage includes all of the benefits traditionally covered by Medicare plus added benefits identified in the benefit plans coverage documents. Such additional benefits may include*:

- Zero dollar monthly health plan premiums (Tribute);
- Preventive care from participating providers with no co-payment.

*Subject to change.

Dual-Eligible Special Needs Plans (DSNP) – **Tribute** is a special type of plan that provides more focused health care for people who have Medicare and are also entitled to assistance from Medicaid. Like all Medicare Advantage plans, it is approved by Medicare. Additionally, it has a contract with the AR State Medicaid program to coordinate Medicaid benefits. Unless the plan has a POS option, all services** must be provided within the network unless an emergency or urgent need for care arises or such service is not available in-network. Some services require prior authorization by Superior Select or its designee.

Institutional Special Needs Plan (ISNP) - *Select* is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. “Point-of-Service” means you can use providers outside the plan’s network for an additional cost.

Provider Services

Providers may contact the contract department at Superior Select via email at networkops@superiorselectinc.com

In addition, Superior Select Provider Relations representatives are available to assist providers. They can be reached via email at info@superioselectinc.com.

Website Resources

Superior Select’s website, www.superiorselectMedicare.com offers a variety of tools to assist providers and their staff.

Available resources include:

- *Provider Manuals*;
- Forms and documents;
- Pharmacy and provider lookup (directories);
- Training materials and job aids;
- Newsletters;
- Member rights and responsibilities; and
- Privacy statement and notice of privacy practices.

Section 2: Provider and Member Administrative Guidelines

Provider Administrative Overview

In accordance with generally accepted professional standards, participating Medicare providers must:

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973;
- Agree to cooperate with Superior Select in its efforts to monitor compliance with its MAP contract and/or MAP rules and regulations, and assist Superior Select in complying with corrective action plans necessary to comply with such rules and regulations;
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Superior Select members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)];

- Use physician extenders appropriately. Advanced Registered Nurse Practitioners (ARNPs) should provide direct member care within the scope or practice established by the rules and regulations of the state and Superior Select guidelines;
- Assume full responsibility to the extent of the law when supervising NPs whose scope of practice should not extend beyond statutory limitations;
- Clearly identify their title (examples: M.D., D.O., ARNP, PA) to members and to other health care professionals;
- Honor at all times any member request to be seen by a physician rather than a physician extender;
- Administer treatment for any member in need of health care services they provide;
- Respond within the identified timeframe to Superior Select's requests for medical records in order to comply with regulatory requirements;
- Maintain accurate medical records and adhere to all Superior Select policies governing the content and confidentiality of medical records as outlined in *Section 3: Quality Improvement* and *Section 8: Compliance*;
- Allow Superior Select to use provider performance data;
- Cooperate with QI activities
- Ensure that:
    - All employed physicians and other health care practitioners and providers comply with the terms and conditions of the Agreement;
    - To the extent the physician maintains written agreements with employed physicians and other health care practitioners and providers, such agreements contain similar provisions to the Agreement; and
    - The physician maintains written agreements with all contracted physicians or other health care practitioners and providers, which agreements contain similar provisions to the Agreement;
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Superior Select, the member, or the requesting party at no charge, unless otherwise agreed;
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen;
- Not discriminate in any manner between Superior Select Plan members and non-Superior Select Plan members;
- Ensure that the hours of operation offered to Superior Select members is no less than those offered to commercial members;
- Not deny, limit or condition the furnishing of treatment to any Superior Select Plan member on the basis of any factor that is related to health status, including, but not limited to the following:
    - Medical condition, including behavioral as well as physical illness;
    - Claims experience;
    - Receipt of health care;
    - Medical history;
    - Genetic information;

    - Evidence of insurability; including conditions arising out of acts of domestic violence; or
    - Disability;
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on the member's behalf for the member's health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify members who are in need of services related to domestic violence, smoking cessation or substance abuse. If indicated, providers must refer members to Superior Select Plan sponsored or community-based programs; and
- Must document the referral to Superior Select-sponsored or community-based programs in the member's medical record and provide the appropriate follow-up to ensure the member accessed the services.

Responsibilities of All Providers

The following is a summary of the responsibilities of all providers who render services to Superior Select members.

Marketing Medicare Advantage Plans

MA plan marketing is regulated by the Centers for Medicare and Medicaid Services (CMS). Providers should familiarize themselves with CMS regulations and the CMS *Medicare Managed Care Manual*. For more information, refer to *Section 8: Compliance* in this Manual.

Maximum Out-of-Pocket

For certain MA member benefit plans, member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a member has reached the maximum out-of-pocket amount for that particular member's benefit plan, a provider should not apply or deduct any member expense from that provider's reimbursement. Providers may obtain a member's maximum out-of-pocket information by contacting Superior Select's Provider Services Department. Superior Select will notify the provider of the member and the amount in excess of the maximum out-of-pocket and the provider shall promptly reimburse the member for the amount in excess of the maximum out-of-pocket amount.

If Superior Select determines that the provider did not reimburse the amount in excess of MOOP to the member, Superior Select may pay such amount due to the member directly, and recoup the amount from the provider. If Superior Select has deducted any member expenses from the provider's reimbursement in excess of the maximum out-of-pocket amount, Superior Select will reimburse the provider for the amount deducted to the extent that Superior Select does not have to repay the member such amount.

Superior Select may audit the provider's compliance with this section and may require the provider to submit documentation to Superior Select supporting that the provider reimbursed members for amounts in excess of the maximum out-of-pocket amounts.

Advance Directives
Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Advance Directives may differ among states.

Each member (age 21 years or older and of sound mind), should receive information regarding Advance Directives. These directives allow the member to designate another person to make medical decisions on the member's behalf should the member become incapacitated.

Information regarding Advance Directives should be made available in provider offices and discussed with the members. Completed forms should be documented and filed in members' medical records.

Providers shall not, as a condition of treatment, require a member to execute or waive an Advance Directive.

Provider Billing and Address Changes
Providers are required to give prior notice to the Provider Relations department for any of the following changes:

- 1099 mailing address;
- Tax Identification Number (TIN) or Entity Affiliation (W-9 required);
- Group name or affiliation;
- Physical or billing address; and
- Telephone and fax number.

Failure to notify Superior Select prior to these changes will result in a delay in claims processing and payment.

Provider Termination
In addition to the provider termination information included in the Agreement, providers must adhere to the following terms:

- Any contracted provider must give at least 90 days prior written notice (180 days for a hospital) to Superior Select before terminating their relationship with Superior Select "without cause," unless otherwise agreed to in writing. This ensures adequate notice may be given to Superior Select Plan members regarding the provider's participation status with Superior Select Plan. Please refer to the Agreement for the details regarding the specific required days for providing termination notice, as providers may be required by contract to give more notice than listed above; and
- Unless otherwise provided in the termination notice, the effective date of a termination will be on the last day of the month.

Please refer to *Section 6: Credentialing* of this Manual for specific guidelines regarding rights to appeal plan termination (if any).

Superior Select will notify in writing all appropriate agencies and/or members prior to the termination effective date of a participating PCP, hospital, specialist or significant ancillary provider within the service area as required by Medicare Advantage program requirements and/or regulations and statutes.

Out-of-Area Member Transfers
Providers should assist Superior Select in arranging and accepting the transfer of members receiving care out of the service area if the transfer is considered medically acceptable by a Superior Select provider and the out-of-network attending physician/provider.

Members with Special Health Care Needs
Members with special health care needs have one or more of the following conditions:

- Intellectual and development disabilities or related conditions;
- Serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia or degenerative neurological disorders;
- Disabilities resulting from chronic illness such as arthritis, emphysema or diabetes; or
- Adults with certain environmental risk factors such as homelessness or family problems that may lead to the need for placement in foster care.

Providers who render services to members with special health care needs shall:

- Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
- Coordinate treatment plans with members, family and/or specialists caring for members;
- Develop a plan of care that adheres to community standards and any applicable sponsoring government agency quality assurance and utilization review standards;
- Allow members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the members' conditions or needs;
- Coordinate with Superior Select, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;
- Coordinate services with other third party organizations to prevent duplication of services and share results on identification and assessment of the member's needs; and
- Ensure the member's privacy is protected as appropriate during the coordination process.

Access Standards
All providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the member's needs.

Superior Select shall monitor providers against the standards below to ensure members can obtain needed health services within acceptable appointment, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Type of Appointment	Access Standard
PCP – Urgent	< 24 hours
PCP – Non-urgent	< 1 week
PCP – Routine	< 30 days
Specialist	< 30 days

In-office wait times shall not exceed 30 minutes.

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- Answering system with option to page the physician for a return call within a maximum of 30 minutes; or
- An advice nurse with access to the PCP or on-call physician within a maximum of 30 minutes.

Please see *Section 11: Behavioral Health* for behavioral health and substance use access standards.

Responsibilities of Primary Care Providers

The following is a summary of responsibilities specific to PCPs who render services to Superior Select Plan members. Coordinate, monitor and supervise the delivery of primary care services to each member:

- See members for an initial office visit and assessment within the first 90 days of enrollment in Superior Select;
- Assure members are aware of the availability of public transportation where applicable;
- Provide access to Superior Select or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity. A related organization or entity is defined as having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office;
- Submit an encounter to Superior Select for each visit where the provider sees the member or the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. For more information on encounters, refer to *Section 5: Claims* in this Manual;
- Ensure members utilize network providers. If unable to locate a Superior Select-participating Medicare Advantage provider for services required, contact the Provider Services department for assistance.
- Comply with and participate in corrective action and performance improvement plan(s).

Primary Care Offices

PCPs provide comprehensive primary care services to Superior Select Plan members. Primary care offices participating in Superior Select's provider network have access to the following resources:

- Support of Superior Select's Provider Relations, Marketing and Sales Departments;
- The tools and resources available on Superior Select's website at www.superiorselectMedicare.com and
- Information on Superior Select network providers for the purposes of referral management and discharge planning.

Closing of Provider Panel

When requesting closure of their panel to new and/or transferring Superior Select Plan members, PCPs must:

- Submit the request in writing at least 60 days (or such other period of time provided in the Agreement) prior to the effective date of closing the panel;
- Maintain the panel to all Superior Select members who were provided services before the closing of the panel; and
- Submit written notice of the reopening of the panel, including a specific effective date.

Covering Physicians/Providers
In the event that participating providers are temporarily unavailable to provide care or referral services to members, providers should make arrangements with another Medicare Dual Advantage Superior Select-contracted and credentialed provider to provide services on their behalf, unless there is an emergency.

Covering providers should be credentialed by Superior Select, and are required to sign an agreement accepting the negotiated rate and agreeing to not balance bill members. For additional information, please refer to *Section 6: Credentialing*.

In non-emergency cases, should a provider have a covering physician/provider who is not contracted and credentialed with Superior Select, contact Superior Select for approval.

Assignment of Primary Care Provider
All Superior Select Plan members will choose a PCP or one will be assigned to the member. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

Termination of a Member
A Superior Select provider may not seek or request to terminate his or her relationship with a member or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required or the cost of covered services required by the member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. In the event that a participating provider desires to terminate his or her relationship with a member, the provider should submit adequate documentation to support that although he or she has attempted to maintain a satisfactory provider and member relationship, the member's non-compliance with treatment or uncooperative behavior is impairing the ability to care for and treat the member effectively. The provider should adequately document in the member's medical record evidence to support his or her efforts to develop and maintain a satisfactory provider and member relationship. If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care for the member until such time that written notification is received from Superior Select stating, *"The member has been transferred from the provider's practice, and such transfer has occurred."*

Adult Health Screening

An adult health screening should be performed by a provider to assess the health status of all Superior Select Plan members. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

Member Administrative Guidelines

Overview

Superior Select will make information available to members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation as well as their rights and responsibilities. Superior Select will convey this information through various methods including an *Evidence of Coverage* booklet.

Evidence of Coverage Booklet

All Superior Select members receive an *Evidence of Coverage* booklet no later than 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later, and annually thereafter.

Enrollment

Superior Select must obey laws that protect from discrimination or unfair treatment. Superior Select does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin.

Upon enrollment with Superior Select Plan, members are provided the following:

- Terms and conditions of enrollment;
- Description of covered non-emergency services in-network and out-of-network (if applicable);
- Information regarding coverage of out-of-network emergency/urgent care services;
- Information about PCPs, such as location, telephone number and office hours;
- Grievance and disenrollment procedures; and
- Brochures describing certain benefits not traditionally covered by Medicare and other value-added items or services, if applicable.

Member Identification Cards

Member identification cards are intended to identify Superior Select Plan members, the type of plan they have and facilitate their interactions with health care providers. Information found on the member identification card may include the member's name, identification number, plan type, PCP's name and telephone number, co-payment information, health plan contact information, and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification

A member's eligibility status can change at any time. Therefore, all providers should request and copy the member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Member Rights and Responsibilities

Superior Select members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in the member's *Evidence of Coverage* booklet and are outlined below.

Members have the right to:

- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- Be treated with fairness, respect, and dignity;
- See Superior Select providers, get Covered Services, and get their prescriptions filled in a timely manner;

- Privacy and to have their protected health information (PHI) protected;
- Information about Superior Select, its network of providers, their Covered Services, and their rights and responsibilities;
- Know their treatment choices and participate in decisions about their health care;
- Use Advance Directives (such as a living will or a durable health care power of attorney);
- Make complaints about Superior Select or the care provided and feel confident it will not affect the way they are treated;
- Appeal medical or administrative decisions Superior Select has made by using the grievance process;
- Make recommendations about Superior Select's member rights and responsibilities policies; and
- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. The information must be given to members in a way they understand.

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell Superior Select and providers if they have any additional health insurance coverage or prescription drug coverage;
- Tell their PCP and other health care providers that they are enrolled in Superior Select Plan;
- Give their PCP and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Understand their health problems and help set treatment goals that they and their doctor agree to;
- Ask their PCP and other providers questions about treatment if they do not understand. Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements;
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices;
- Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they get. Members must also meet their other financial responsibilities as described in the *Evidence of Coverage* booklet;
- Inform Superior Select if they move; and
- Inform Superior Select of any questions, concerns, problems or suggestions by calling the Member Service Department listed in their *Evidence of Coverage* booklet.

Changing Primary Care Providers

Members may change their PCP selection at any time by calling Superior Select's Member Service Department.

Women's Health Specialists

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct, in-network access to a women's health specialist for Covered Services related to this type of routine and preventive care.

Hearing-Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to Superior Select members through Member Service. PCPs should coordinate these services for members and contact Member Services if assistance is needed.

Section 3: Quality Improvement

Overview

The Quality Improvement (QI) Program is comprehensive, systematic and continuous. It applies to all member demographic groups, care settings, and types of services afforded to Medicare Advantage members, including the Dual Special Needs Plan membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- Utilization Management
- Care Management/ Disease Management
- Quality Improvement Projects
- Chronic Care Improvement Projects
- Network Adequacy
- Preventive and Clinical Health
- Quality of care and service utilization
- Coordination and Continuity of Care
- Credentialing
- Appeals and Grievances
- Member and Provider Satisfaction
- Components of Operational Service
- Contractual, Regulatory and Accreditation Reporting Requirements

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. CQI processes identified in the QI Program Description, Work Plan and Annual Evaluation are approved by the applicable Committees and conducted to accomplish identified goals. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources.

The annual QI Work Plan identifies specific activities and projects to be undertaken by Superior Select and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual, accreditation and/or regulatory requirements and identify measurements to accomplish goals. The Annual QI Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years trending as appropriate. The Annual Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and projects
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals
- An analysis of accomplishments in the quality of clinical care and service
- current opportunities for improvement with recommendations for interventions

Each QI process is continually improved by analyzing and acting to ensure consistency across the enterprise, thus becoming more efficient and effective. The Plan-Do-Study-Act (PDSA) method of CQI is utilized throughout the organization. Under the PDSA approach multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care and service delivery. When variations are noted, root cause analysis, action plans and re-measurement occur to ensure progress toward established goals.

The CQI strategy noted above is demonstrated in the structure of the QI Program's committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained. Monitoring of quality of care interventions and outcomes through HEDIS® measure reviews, external quality review studies, periodic medical record reviews (for chart maintenance, documentation legibility, disease management compliance; continuity of care coordination, information security) and as required by CMS.

Program Methodology

The QI Program methodology involves a review of the complete range of health services provided to members as categorized by all demographic groups, including those with special healthcare needs, clinically related groups, and service settings for clinical and non-clinical measures.

The QI Program is based on the latest available research in the area of quality assurance and at a minimum includes a method of monitoring, analysis, evaluation and improvement in delivering quality care and service. The QI Program involves tracking and trending of quality indicators to ensure measures are reported, outcomes are analyzed, and goals are attained. Federal and state contractual standards, evidence-based practice guidelines, and other nationally recognized sources Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Health Outcomes Survey (HOS) and HEDIS) may be utilized to identify performance/metric indicators, standards, and benchmarks. Indicators are objective, measurable, and based on current knowledge and clinical experience (as applicable). The indicators may reflect, without limitation, the following parameters of quality:

- Structure, process, or outcome of care
    - Administrative and care systems within clinical services to include
        - Acute and chronic condition management
        - Care management
        - Disease management
        - Utilization management
        - Credentialing
        - Member and provider satisfaction
        - Medical record review
        - Member complaints and appeals
        - Practitioner availability and accessibility
        - Plan accessibility
        - Member safety
        - Preventive care
        - Disparities in care

HEDIS measures and CAHPS and HOS results are integrated in the QI Program. HEDIS measures and methodology may be adopted as performance indicators for clinical improvement. The CAHPS survey is utilized as one of the tools for assessing member satisfaction. The HOS is used to assess the member's physical and mental well-being at the beginning and end of a two-year cycle.

Quality initiatives are developed and implemented as indicated by data analysis for process improvements. Initiatives are reassessed on an annual basis to evaluate intervention effectiveness and compare year-to-year performance.

Data Collection Process for Performance Measure Evaluation

Data is collected on a routine basis (monthly, quarterly, and/or annually) and on an ad hoc basis from internal and external sources to systematically and objectively monitor, analyze, evaluate, and report health outcomes and indices of quality. Data collection follows protocols established in approved policies or QI program design. Data related to all aspects of member services, departmental operations and outcomes may be collected.

Data Sources

Data sources may be administrative, surveys, medical records, or a combination. Data sources may include, without limitation: Enrollment information, claims, encounters, authorizations, appeals, complaints, disease/Care management documentation, access and availability survey findings, member medical records within provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, QI studies, CAHPS, HOS and HEDIS results.

Data sources may also include a review of member medical records within provider offices and facilities and surveys by external bodies such as accreditation entities or CMS, QI studies, HOS, CAHPS, and HEDIS results as well as Standard and Process standards.

Superior Select integrates data from multiple sources to produce clinically relevant data on an ongoing basis for quality reporting. Superior Select utilizes a software system and all data is entered into the system electronically. This program is used for HEDIS reporting on a monthly, quarterly and annual basis.

On a monthly basis, the system is refreshed and Superior Select reviews the volume of data by submitter to ensure data is coming in and is being captured for quality reporting. In addition, HEDIS reports are run monthly and HEDIS Provider Profiles are produced which track and trend Provider HEDIS rates. This enables Superior Select to conduct follow up with high volume and other key providers/provider groups for education regarding HEDIS rates, benchmarking for comparison to peers, the overall plan rate and the NCQA thresholds.

Superior Select's Care Management Department and QIC review information received from all functional areas and assure accuracy and completeness. Structure and Process Measure comments and recommendations by auditors are distributed to the appropriate functional area(s) for review, development of process improvement activities/interventions, implementation of activities, and ongoing monitoring/evaluation for outcomes.

Superior Select identifies its most vulnerable subpopulations by utilizing an algorithm which incorporates medical, behavioral, and pharmaceutical claims and encounter data. Each member identified by the

algorithm is assigned a score based on three primary drivers: severity, utilization and cost. In addition to being assigned a score, members are flagged when specific chronic conditions exist.

Data Collection Methodology
Data collection is the responsibility of the department or functional area conducting the related QI activity. Medical data collected manually is completed by qualified staff (i.e. data extraction from medical records is completed by, or under the direction of licensed personnel). If data collection includes a medical decision rendered by a physician then the collection must be performed by a physician. Data collection follows protocols established in approved policies or program design. Manual data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications.

To ensure accuracy and completeness of structure and process data all Care Management staff receives initial training regarding the internal data system, conducting the assessments and documentation.

Internal audits are conducted on a monthly basis to ensure appropriate/accurate data is captured by the care manager. A minimum number of files are reviewed and findings are discussed with the care manager. Coaching and additional training is conducted when deficiencies are identified.

Data and Record Maintenance
All data collected is maintained for a period of 10 years as required by CMS. Electronic data from claims and encounters is stored in the internal electronic system and is available for query for an unlimited period of time. All queries used to produce data are stored on shared drives and version controlled to allow for replication of data. Data is backed up nightly and back-up tapes are archived on an ongoing basis.

QIC, Sub-Committee agendas, minutes, action registers, Quality Improvement Projects (QIPs), annual evaluations and work plans are maintained electronically and in hard copy to have available as needed for CMS.

Member data is housed in EMMA (Enterprise Medical Management Application) for use by care managers, coordinators, social workers and nurses as needed for care/disease management and utilization, including quality of care review.

Data Analysis for Performance Measure Evaluation
Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Superior Select's clinical and service performance goals. These analyses will take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan may be initiated as a result of findings or reprioritization of projects and new events.

Analyses and QI Program reports are communicated to the QIC and UMAC. Summary reports are presented to the Board. The QI Program Description and initiative outcomes are available to providers and members upon request. An annual summary of the QI Program Evaluation is presented in the member and provider newsletters. The QIC and MAC have a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff members.

Quality Improvement Activities

A critical component of the Superior Select QI Program is in regard to the identification and collection of data that is meaningful and relevant to the population served. Continuing through the PDSA QI process, outcomes, limitations and barriers to goal attainment are identified, strategic planning is conducted and interventions are implemented. Goals and objectives are identified and revised through a continuation of these activities with the knowledge that for some member's health outcomes may involve a continuation verses deterioration of health status, completion of recommended preventive screenings, a safe living environment or the timely access to appropriate medical and behavioral health care.

The initial data sources utilized in the QI process for Members include the Health Risk Assessment (HRA), Comprehensive Medical Assessment and individualized plan of care which also addresses behavioral health care needs. Since care management services are offered to all eligible members this is the most readily available data for new members. In addition, the initial communication and ongoing collaboration with treating providers is an integral and invaluable data source and component of the process to improve member outcomes. Additional data sources are utilized as data is available and are noted in the subsequent section.

QI Program Activities may be identified through a review of clinical and non-clinical service population data. For established programs, HEDIS® data is recognized through the industry as a publicly reported measure of the quality of care members receive. HEDIS data is routinely monitored to identify QI activities relevant to the population for which interventions have the potential to impact member outcomes.

HEDIS data is benchmarked against the NCQA benchmarks and thresholds to determine areas of improvement needed. A root cause analysis is performed to determine barriers. HEDIS results and root cause analysis are analyzed and reviewed at the Medical Advisory Committee for input from network participating providers. The results are then reviewed at the QIC and action plans are developed to create initiatives to ensure sustained improvement in the measures. HEDIS data is reviewed monthly and quarterly throughout the year to make adjustments in initiatives to ensure members are receiving the care they require.

Reports of Structure and Process measure results are reviewed and analyzed within the Care Management and other applicable Superior Select departments and the QIC. Workgroups are utilized to identify and implement appropriate interventions for process improvement.

Data Analysis and Evaluation

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Superior Select's clinical and service performance goals. These analyses will take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan may be initiated as a result of findings or reprioritization of projects and new events.

Analyses and QI Program reports are communicated to the relevant quality committee. Summary reports are presented to the Board. The QI Program Description and initiative outcomes are available to providers and members upon request. An annual summary of the QI Program Evaluation is presented in the member and provider newsletters. The QIC has a responsibility to disseminate information regarding QI Program activities and outcomes internally to staff members.

Data Analysis and Quality Improvement Projects (QIPs) 42CFR §422.152(c)-(d)]
QI activities are not limited to those that will improve compliance with a contractual or regulatory requirement. Any individual, functional area or department within the Superior Select system may identify and design/develop a formal or informal QI activity. The activity may be the result of identification of an issue or the desire to improve performance of a particular function. Proposed QI activities are presented for review and approval by the QIC.

QIP initiatives are determined by their relevancy to the Medicare member population. Superior Select may utilize HEDIS results, quality outcomes, indices of quality, customer service metrics, HOS and customer satisfaction to determine the needs of the members for QI activities. The metrics are reviewed by Superior Select's Medical Advisory Committee and QIC to determine which metrics may influence Superior Select's goal of standardizing care, improving processes and outcomes of health care or services and have a potentially significant impact on beneficiaries' health, functional status or satisfaction.

Once an aspect of clinical care or non-clinical care that warrants QI is identified the goals of a QIP would include:

- Determination of a benchmark that reflects established performance through comparative data to support the basis on which the goal was established such as HEDIS percentile thresholds, nationally-recognized clinical practice guidelines, literature search for nationally published benchmarks;
- Collection of baseline data;
- Conducting a barrier analysis to assist in determining the appropriate interventions to improve performance;
- Implementing interventions;
- Conducting a re-measurement at predetermined intervals, adjusting interventions if needed and ultimately achieving significant improvement sustained over time.

Superior Select initiatives to improve service and health outcomes of members include the initiation and evaluation of QIPs that focus on clinical and non-clinical topics relevant to the population with the ability to impact change for improvements. Superior Select may utilize HEDIS results, quality outcomes, indices of quality, customer service metrics, HOS and customer satisfaction to determine the needs of the members for QI activities. Data may be collected at specified intervals i.e. ongoing, ad hoc, monthly, semi-annual, but at a minimum annually. Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving clinical and/or service performance goals. Barriers for achieving desired outcomes and interventions or strategies recommended are considered in the analysis. Data is aggregated to track and trend over time for identification of optimal and sub-optimal plan performance. Based on the analysis of the results, new interventions or current interventions may be revised.

The metrics are reviewed by Superior Select's Medical Advisory Committee and QIC to determine which metrics may influence Superior Select's goal of standardizing care, improving processes and outcomes of health care or services and have a potentially significant impact on beneficiaries' health, functional status or satisfaction.

QI project indicators are objective and measurable, methodology is statistically valid, and remeasurement occurs at specified intervals, i.e. ongoing, ad hoc, monthly, semi-annually, but at a minimum annually through the HEDIS Effectiveness of Care Measures results or the quality indices and outcomes measurements. Benchmarks are used to determine the effectiveness of interventions and identify trends and opportunities for improvement. The source of the benchmark may be identified using NCQA HEDIS

Percentiles, CPGs, AHRQ, and Healthy People 2020. Measurement results are reviewed by appropriate staff, barrier analysis to achieving desired goal is conducted and interventions implemented. Superior Select's interventions may be system-wide or population specific and include the establishment or alteration of practice guidelines as appropriate. The QIC reviews and approves all QIPs. Status reports and results of QI projects are available when requested.

QIPs are initiated and/or sustained on an annual basis in alignment with requirements noted in the Medicare Managed Care Manual.

Data Reporting

Superior Select has implemented the Part C Technical Specifications provided by CMS for the data measure as it relates to its Part C Reporting Requirement. The respective Superior Select Functional Area (WFA) will collect data, whether internal or external (Delegated Entity), and validate that data, which may include, but is not limited to, validation of databases used in preparing and or housing any data, comparing to prior reports for trend analysis, and ensuring it meets the current CMS Validation Standards by aligning to various tools such as the OAI (Organizational Assessment Instrument). Additionally, an Enterprise Compliance System is purported to capture the data and associated WFA attestations, where it will then be reviewed further by Regulatory Affairs and Medicare Compliance and Audit.

Superior Select ensures accuracy of the data elements by ensuring alignment to the OAI, various validation standards of both an internal and external nature, varying levels of subsequent analysis of data by different groups, and overall adherence to the CMS Data Validation Standards.

Operationally, data is reviewed / analyzed by the WFA, and consequently, steps are taken to increase performance outcomes and overall improvement of the Model of Care program.

Superior Select collects and reports HEDIS and Structure and Process measure data annually for all Medicare plans with 30 or more members. Data is primarily extracted from documentation in the EMMA system by the Medical Economics Department and reported to the Care Management Department. Cross functional areas within Superior Select collaborate to gather the information, documents and reports for submission. Other sources for which information is collected include, but are not limited to member and provider brochures, policies and procedures.

Superior Select participates in the CAHPS and HOS as required by CMS on an annual basis. Superior Select contracts with an NCQA-certified survey vendor to conduct the HOS survey on all plans required to collect and report CAHPS and HOS data. The survey vendor utilizes the NCQA-required survey techniques and follows the specifications as required by NCQA. Superior Select works with the survey vendor to ensure the data is collected timely and appropriately. The results are then sent to CMS via the survey vendor who in turn reports the information to Superior Select.

Annually, CAHPS and HOS data is evaluated to determine areas of needed improvement and the needs of the population served under the Medicare program. The HOS is used to assess the member's physical and mental well-being at the beginning and end of a two year cycle.

The CAHPS and HOS results are presented to the Medical Advisory Committee to obtain input from the network participating providers regarding the needs of the population served based on deficiencies and areas of opportunity identified. As data is evaluated initiatives are put into place to improve the health

outcomes of Superior Select's beneficiaries. Action plans are developed to address the deficiencies and identify areas of needed improvement. The data and action plans are evaluated by the QIC for approval.

Concerns/Complaints/Grievances

42 CFR §422.152(f)(3)

Members, practitioners, and providers are encouraged to contact Superior Select to report issues. Concerns can be reported via telephone, the website or in writing. Issues are documented in a common database to enable appropriate classification, timely investigation and accurate reporting of issues to the appropriate quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it Superior Select, practitioner, or provider focused.

Continuity and Coordination of Care

Superior Select's activities encourage the PCP relationship as the member's provider "home". This strategy promotes one provider having comprehensive knowledge of the member's health care needs, whether it is disease or preventive care in nature. Through contractual language and program components, PCPs are educated regarding their responsibilities.

The scope of continuity and coordination of care activities includes, but is not limited to, assessment for timely care post facility discharge, appropriate transition of members from one level of care to another and medical record documentation that reflects presence of consultant's notes, as appropriate.

Credentialing

Credentialing is the process by which peers evaluate an individual applicant's background, education, training, experience, demonstrated ability, patient admitting capabilities, licensure, regulatory compliance and health status (as applicable). This evaluation is performed through primary and secondary source verifications obtained in accordance with regulatory, accreditation and Superior Select's corporate policy and procedure. Information and documentation for individual practitioners or facilities is collected, verified, reviewed and evaluated, in order to approve or deny provider network participation. Approved providers are assigned a specialty and scope of practice that is consistent with their boards of certification, accredited training or licensure, as applicable. Specialty designations and delineation of scope of services of approved facilities is consistent with recognized industry service standards and/or standards of participation developed by Superior Select corporate that may include certification, licensure, and/or accreditation, as applicable to provider type. Re-credentialing of a provider shall be undertaken at least every 36 months. Monitoring and evaluation of the quality and appropriateness of patient care, clinical performance, and utilization of resources of providers is incorporated in the re-credentialing process as follows:

1) Credentialing and re-credentialing:

   Scope of practice is reviewed as outlined in policy and procedure. Input from the QI activities is utilized on an ongoing basis to ensure that each provider's scope of practice and credentials are commensurate with the provider's actual practice and abilities

2) Re-credentialing:

   At the time of re-credentialing, in addition to information obtained through the recredentialing application, a site survey (as applicable), findings of the primary source verification process, and relevant findings from any of the QI activities listed below may be considered components of the re-credentialing process of the practitioner or other healthcare provider:

   a) Medical record review

b) Diagnosis specific screens
c) Age specific screens for preventive care
d) Utilization review screens
e) Sentinel events
f) Peer review
g) Risk management issues
h) Member complaints and grievances
i) Member satisfaction

Ongoing compliance with Superior Select policies and procedures is assessed through a variety of methods. Providers failing to meet established standards, such as the presence of sanctions or limitations on licensure, instances of poor quality, etc., will be reviewed by the Credentialing Committee, with avenues of recourse being corrective actions, sanctions or provider termination. Reporting to appropriate regulatory bodies will occur as needed.

Medical Record Review

Medical record review is one aspect of provider oversight conducted to assess and improve the quality of care delivered to members and the documentation of such care. The focus of the review may include, without limitation, patient safety or quality of care issues, clinical and/or preventive guideline compliance, HEDIS, over- and under- utilization of services, confidentiality practices and inclusion of consideration of member input into treatment plan decisions. The review process allows for identification of the provider's level of compliance with contractual, accreditation, and regulatory standards achieved. Provider training is conducted as needed to facilitate greater compliance in future assessments.

Member Satisfaction

Member satisfaction surveys are conducted and analyzed on an annual basis. Member complaints, grievances, and inquiries are reviewed and analyzed on a continuous basis as a measure of member satisfaction. Low or inadequate scores are examined and a root cause analysis is completed. Opportunities for improvement are identified. Interventions such as changes in work flows and/or processes are identified and implemented to improve member satisfaction.

Operational Service Performance

Statistics regarding Superior Select's status of operational performance are continuously tracked and trended. These include, but are not limited to, the call center activities and claims processing metrics. Results that are below Superior Select's designated goals initiate the development and implementation of a corrective action plan.

Peer Review

The Medical Director is responsible for peer review activities. Peer review is conducted during the investigation of quality of care or service concerns including potential compromises of member safety. There are multiple reasons such investigations may be initiated, including adverse/sentinel events, member complaints, over/under utilization comparisons and coordination/continuity of care statistics. The scope of the review encompasses medical, behavioral, and pharmaceutical services as applicable and determines if there is evidence of poor quality.

The Credentialing Committee functions as Superior Select's peer review committee for quality of care or conduct issues.

All aspects of peer review are deemed confidential, including findings and documents, and are protected from disclosure to the extent prescribed under state law. All persons involved with peer review activities adhere to the confidentiality guidelines applicable to medical staff committees.

Peer review may include the following:

- Evaluation of the appropriateness, adherence to standards and outcome of care generally accepted by professional group peers
- Morbidity/mortality review
- Complaints/grievances related to medical or behavioral health treatment
- Proper maintenance of medical records requirements
- Review of written and oral allegations of inappropriate or aberrant service

All peer review is documented and maintained in a locked file by the Credentialing Department.
Peer review that results in a favorable determination is summarized for the Credentialing Committee on a monthly basis. Issues requiring further review, action, or disciplinary action are forwarded to the next scheduled Credentialing Committee meeting. If the issue requires immediate action, an ad hoc committee meeting is convened in accordance with policy. Any issues that are felt to be litigious in nature are referred to Risk Management immediately.

Any quality deficiencies that result in provider suspension or termination are reported to the National Practitioner Data Bank, Department of Professional Regulation and the Department of Insurance.

The information gathered on individual providers is compiled into a provider profile and is submitted to the Credentialing Department for coordination with any other performance monitoring activities, including utilization review, risk management, and resolution and monitoring of member grievances, for the purpose of re-credentialing.

Pharmacy Program

Superior Select Plan provides access to quality, cost effective medications for eligible beneficiaries by maintaining a network of conveniently located pharmacies. An electronic adjudication system efficiently processes prescription drug claims at the point of dispensing to confirm eligibility, make drug and benefit coverage determinations, evaluate for patient safety and adjudicate the claim with the appropriate pharmacy provider payment. Network contracting and the adjudication of pharmacy claims are managed by a pharmacy benefit manager (PBM), EnvisionRx. Superior Select has oversight of the PBM for these functions. Pharmacy provides a prescription drug formulary which is created and modified through the Pharmacy and Therapeutics (P&T) Committee. Pharmacy reviews and responds to all drug exception requests or coverage determinations (DERs) and medication appeals (redeterminations) through a formalized process that utilizes the drug formulary, prior authorization protocols and prescriber supplied documentation. Pharmacy coordinates onsite and telephonic interactions with prescribing providers to evaluate, review and guide physician prescribing practices through a network improvement program (NIP). Emphasis is placed on the quality of care of members through Medication Therapy Management (MTM) services as well as quality initiatives which include, but are not limited to, member and prescriber outreach and coordinated efforts with Quality Improvement Organizations (QHCMs).

It is the policy of Superior Select for its Pharmacy Department to notify members who have received a medication affected by a Class 1 and/or a Class 2 retail level recall as well as its authorized prescribers.

Superior Select's Pharmacy Department shall also notify affected members and authorized prescribers of market withdrawals.

Provider Satisfaction

An ongoing analysis of provider complaints is conducted to evaluate provider satisfaction. In addition, the provider network is formally surveyed on an annual basis to assess provider satisfaction with Superior Select. Results are analyzed; an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the QIC for approval and recommendations.

Sales and Marketing

Sales and marketing activities are regulated by CMS and policies and procedures are developed to ensure all requirements are met. Sales and marketing activities are integrated in the QI Program to monitor promotional activities and ensure population needs are met from a geographic and demographic perspective. Sales and marketing reports are reviewed at least quarterly at the QIC and action plans are developed to improve member retention and improve member satisfaction.

Care Management/Service Coordination

The mission of the Care Management Department is to coordinate timely, cost effective, integrated services for the individual health needs of members to promote positive clinical outcomes. For members who also have Medicaid with Superior Select, providers will hear this benefit being called Service Coordination.

Complex care management is defined as the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help in navigating the system to facilitate appropriate delivery of care and services. The goal of complex care management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a care management plan with performance goals, monitoring and follow-up. Superior Select assists members with multiple or complex conditions to obtain access to care and services, and coordinates their health care.

Members will be considered complex based on the above definition and may have any diagnosis if the member's medical and /or behavioral health condition require extensive coordination intervention on behalf of the care manager. Examples of the types of members for which Superior Select conducts complex care management, includes, *but is not limited to* the following:

- Catastrophic
- Oncology
- Wound Care
- Special Health Care Needs
- Transplant
- HIV/AIDS
- Multiple Chronic Illnesses
- Chronic Illness that results in high utilization
- Debilitating behavioral health condition

Patient Safety

The QI program includes an emphasis on patient safety. Superior Select monitors aspects of the patient safety that include but are not limited to:

- Physician credentials are verified in accordance with state, federal and regulatory guidelines.
- The Quality of Care program monitors potential adverse events referred from any part of the health care system.
- The process of utilization management plays a vital role in the monitoring of patient safety through concurrent review, identification of potential quality of care issues, and identification of potential trends in under and over-utilization.
- Member complaints are monitored for quality of care issues. These complaints are investigated and analyzed, and are referred to appropriate committee as necessary.
- The Drug Utilization Review (DUR) program, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the age or gender of a member; or other pharmacy problems at the time a prescription is filled.

Utilization Management

Utilization management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating the utilization of healthcare services. The UM Program is a multidisciplinary, comprehensive process to manage resource utilization for optimal member outcomes. Integral factors in the UM process include:

- Consideration of individual member clinical needs, including those identified with special healthcare needs, cultural characteristics, safety and preferences
- An available and accessible care delivery system
- A diverse network of qualified providers
- Clinically sound, evidence-based medical/behavioral health necessity decision-making tools to facilitate the consistent application of criteria for appropriate utilization of available resources in an efficient and effective manner
- Available and applicable plan benefits

The UM Program includes components of prior authorization as well as prospective, concurrent and retrospective review activities, each of which are designed to provide for an evaluation of health care and services based on the member's coverage, the appropriateness of such care and services and, to determine the extent of coverage and payment to providers of care. Superior Select does not reward its associates or providers, physicians or other individuals or entities performing UM activities for denying coverage, services or care, and financial incentives, if any, do not encourage or promote under-utilization.

The multidisciplinary staff and practitioners employed by Superior Select conduct UM activities within their legal scope of practice as identified by licensure standards.

Health Risk Assessment

When a Medicare member enrolls with Superior Select, an initial comprehensive HRA is completed within the first 90 days of enrollment to capture needed information. A secondary assessment is conducted by the care manager to gather additional needed information. The completed HRA information as well as the

secondary assessment is utilized to develop the member care plan. A plan of care is completed with the member and shared with the PCP, specialists (if any exist), and other members of the Interdisciplinary Care Team (ICT).

On follow-up calls the care manager addresses member progress in meeting the short and long term goals established. This is documented in the medical record and any significant health status changes are shared with the ICT.

Model of Care

The Model of Care targets the population and identifies specific specialized needs so resources and services are available to those who need them. Effectiveness of the Model of Care will be evaluated through the specific measureable goals and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes analyzed, interventions implemented for goal attainment and reports generated. Data collection follows protocols established in approved policies or program design. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records.

Superior Select Plan has established performance outcomes to evaluate and measure the quality of care, quality outcomes, service and access for members. For each metric benchmarks have been established based on evidenced-based medicine found by current literature, standards and guidelines. A corrective action plan will be created and interventions identified for each indicator that fell below the desired value. The analysis, process improvement plan, implementation of interventions and improvements will be reported to the QIC for review, feedback, and approval.

Medical Records

Medical records should be comprehensive and reflect all aspects of care for each member. Records are to be maintained in a secured location. Documentation in the member's medical record is to be completed in a timely, legible, current, detailed and organized manner which conforms to good professional medical practice. Records should be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Complete medical records include, but are not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other health care professionals' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided

Medical records must be signed and dated.

Superior Select may conduct reviews of the medical records of contracted providers to determine compliance with established documentation standards, professional practice guidelines and preventive health guidelines. In accordance with Superior Select's contract with CMS and requirements from federal and state

regulatory agencies, Superior Select is required to periodically assess the medical records of members to demonstrate compliance with these requirements.

Medical record reviews may be conducted to assess the quality of care delivered and documented. Medical record reviews consist of a general documentation section and an adult preventive care section. In the medical record review, the two sections are reviewed for compliance with the required elements. If a provider does not attain a composite score of 80% or greater, a corrective action plan and a medical record re-evaluation is required. Information from the medical record review may be used in the re-credentialing process, as well as quality activities.

The general documentation requirements for medical records are below.

All medical records, including all entries in the medical record, at a minimum must:

- Be neat, complete, clear, and timely and include all recommendations and essential findings in accordance with accepted professional practice;
- Be signed and include the name and profession of the provider;
- Be legible to readers and reviewing parties;
- Be dated and recorded in a timely manner;
- Include the member's name (first and last name or identifier) on each page;
- Include the following personal and biographical data in the record:
    - Name;
    - Member identifier;
    - Date of birth;
    - Gender;
    - Address;
    - Home/work telephone numbers;
    - Emergency contact name and telephone numbers. This may include next of kin or name of spouse;
    - Legal guardianship, if applicable;
    - Marital status; and
    - If not English, the primary language spoken by the member and, if applicable, any translation or communication needs are addressed;
- Include allergies and adverse reactions to medication;
- Include a HIPAA protected health information release;
- Include a current medication list;
- Include a current diagnoses/problem list;
- Include a summary of surgical procedures, if applicable;
- Include age-appropriate lifestyle and risk counseling;
- Include screening for tobacco, alcohol or drug abuse with appropriate counseling and referrals, if needed;
- Include screening for domestic violence with appropriate counseling and referrals, if needed;
- Include the provision of written information regarding advance directives to adults (18 years and older);
- Include an assessment of present health history and past medical history;
- Include education and instructions, verbal, written, or by telephone;

- Include, if surgery is proposed, a discussion with the member of the medical necessity of the procedure, the risks, and alternative treatment options available;
- Include evidence that results of ordered studies and tests have been reviewed;
- Include consultant notes and referral reports;
- Include evidence of follow-up visits, if applicable; and
- Include appropriate medically indicated follow-up after hospital discharge and emergency department visits.

Clinical encounters/office visits must minimally include:

- Chief complaint;
- History and physical examination for presenting complaint;
- Treatment plan consistent with findings; and
- Disposition, recommendations and/or instructions provided.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Superior Select or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to Superior Select upon request.

The member's medical record is the property of the provider who generates the record. However, each member or their representative is entitled to one free copy of his or her medical record. Additional copies shall be made available to members upon request and providers may assess a reasonable cost.

Superior Select follows State and Federal law regarding the retention of records remaining under the care, custody, and control of the physician or health care provider. Information from the medical records review may be used in the re-credentialing process as well as quality activities.

For more information on medical records compliance, including but not limited to, confidentiality of member information and release of records, refer to *Section 8: Compliance* of this Manual.

Section 4: Utilization Management, Care Management and Disease Management

Utilization Management

Overview

The Utilization Management (UM) Program defines and describes Superior Select's multidisciplinary, comprehensive approach and process to manage resource allocation. The UM Program describes the use of the Clinical Services Department's review guidelines, Superior Select's adverse determination process, the assessment of new technology, and delegation oversight.

The UM program includes components of prior authorization, concurrent and retrospective review activities. Each component is designed to provide for the evaluation of health care and services based on member coverage, appropriateness of such care and services, and to determine the extent of coverage and payment to providers of care.

Superior Select does not reward its associates, practitioners, physicians, or other individuals or entities performing utilization management activities for rendering denial of coverage, services or care determinations. Superior Select does not provide for financial incentives, encourage or promote under-utilization.

Medical Necessity

Medically necessary services are defined as services that include medical or allied care, goods or services furnished or ordered to:

- Be necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
- Be consistent with the generally accepted professional medical standards and not be experimental or investigational;
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied health goods or services does not, in itself, make such goods or services medically necessary or a Covered Service/benefit.

Prior Authorization

Prior authorization allows for efficient use of Covered Services and ensures that members receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the member's PCP, treating specialist, or facility. Superior Select provides a process in order to make a

determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.

Providers may submit requests for authorization by:

- Faxing a properly completed *Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, Home Health and Skilled Therapy Services Authorization Request Form*;
- Contacting Superior Select via phone for inpatient notifications and urgent outpatient services; or

It is necessary to include the following information in the request for services:

- Member name and identification number;
- The requesting provider's demographics;
- Diagnosis code(s) and place of service;
- Services being requested and *Physician's Current Procedural Terminology, 4th Edition* (CPT-4) code(s);
- The recommended provider's demographics to provide the service; and
- Medical history and any pertinent medical information related to the request, including current plan of treatment, progress notes as to the necessity, effectiveness, and goals.

Notification

Notifications are communications to Superior Select with information related to a service rendered to a member or a member's admission to a facility. Notification is required for a member's admission to a hospital. This enables Superior Select to log the hospital admission and follow up with the facility on the following business day to receive clinical information. Notification can be submitted by fax or phone. The notification information should include member demographics, facility name and admitting diagnosis.

Concurrent Review

Superior Select ensures the oversight and evaluation of members when admitted to hospitals, rehabilitation centers, and skilled nursing facilities (SNF). This oversight includes reviewing continued inpatient stays to ensure appropriate utilization of health care resources and to promote quality outcomes for members.

Superior Select provides oversight for members receiving acute care services in facilities mentioned above to determine the initial/ongoing medical necessity, appropriate level of care, appropriate length of stay, and to facilitate a timely discharge.

Concurrent review is initiated as soon as Superior Select is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity. The continued length of stay Authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;
- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning;
- Identify referrals appropriate for DM or quality-of-care review; and
- Identify cases appropriate for follow up by the CM/Service Coordinator.

Concurrent review decisions are made utilizing the following criteria:

- InterQual™;

- Superior Select Clinical Coverage Guidelines;
- Medical necessity;
- Member benefits;
- State Provider Handbooks, as appropriate;
- Federal statutes and laws;
- Medicare guidelines; and
- Hayes Health Technology Assessment.

These review criteria are utilized as a guideline. Decisions will take into account the member's medical condition and co-morbidities. The review process is performed under the direction of the Superior Select Medical Director.

Frequency of onsite and/or telephonic review will be based on the clinical condition of the member. The frequency of the reviews for extension of initial determinations is based on the severity/complexity of the patient's condition, necessary treatment and discharge planning activity including possible placement in a different level of care.

The treating provider and the facility utilization review staff will provide review information that is collected telephonically or via fax.

Clinical information is requested to support the appropriateness of the admission, continued length of stay, level of care, treatment and discharge plans.

When a hospital determines that a member no longer needs inpatient care, but is unable to obtain the agreement of the physician, the hospital may request a Quality Improvement Organization (QHCM) review. Prior to requesting a QHCM review, the hospital should consult with Superior Select.

Discharge Planning

Superior Select identifies and provides the appropriate level of care as well as medically necessary support services for members upon discharge from an inpatient setting. Discharge planning begins upon notification of the member's inpatient status to facilitate continuity of care, posthospitalization services, referrals to a SNF or rehabilitation facility, evaluating for a lower level of care, and maximizing services in a cost-effective manner. As part of the UM process, Superior Select will provide for continuity of care when transitioning members from one level of care to another. The discharge plan will include a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional setting. This will be based on the information received from the institution and/or provider caring for the member.

Some of the services involved in the discharge plan include, but are not limited to:

- DME;
- Transfers to an appropriate level of care, such as an inpatient nursing rehabilitation (INR) facility, long term acute care facility (LTAC) or SNF;
- Home Health Care;
- Medications; and
- Physical, Occupational, or Speech Therapy (PT, OT, ST).

Retrospective Review

A retrospective review is any review of care or services that have already been provided.

There are two types of retrospective reviews which Superior Select may perform:

- Retrospective Review initiated by Superior Select
  Superior Select requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the provider submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Superior Select to support accurate coding and claims submission.
- Retrospective Review initiated by providers
  Superior Select will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the member was not eligible, but became eligible with Superior Select retroactively or in cases of emergency treatment and the payer is not known at the time of service. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member's needs at the time of service. Superior Select will also identify quality issues, utilization issues and the rationale behind failure to follow Superior Select's Prior Authorization/pre-certification guidelines.

The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member's needs at the time of service. Superior Select will also identify quality issues, utilization issues, and the rationale behind failure to follow Superior Select's prior authorization/precertification guidelines.

Superior Select will give a written notification to the requesting provider and member within 30 calendar days of receipt of a request for a UM determination. If Superior Select is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to 14 calendar days of the post-service request.

Referrals

Superior Select does not require referrals from PCP for Specialist care. However, if a referral is made, the PCP must document the reason for the referral and the name of the specialist in the member's record. The specialist must document receipt of the request for a consultation. Superior Select does not require a written referral as a condition of payment for most services. No pre-communication with Superior Select is necessary. If member is using a POS benefit, the member's PCP should always coordinate care with out-of-network providers and contact Superior Select for authorization and approval. The PCP may not refuse to refer to non-network providers, regardless of medical group or independent practice association affiliation.

Criteria for Utilization Management Determinations

The UM Department utilizes review criteria that are nationally recognized and based on sound scientific medical evidence. Providers with an unrestricted license, professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following list when making coverage determinations:

- InterQual;
- Medical necessity;
- Member benefits;

- Federal statutes and laws;
- Medicare guidelines;

The nurse reviewer and/or medical director apply medical necessity criteria in the context of the member's individual circumstance and capacity of the local provider delivery system. When the above criteria do not address the individual member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

Members and providers may request a copy of the criteria utilized for a specific determination of medical necessity by contacting Customer Service.

The medical review criteria stated below are updated and approved at least annually by the Medical Director, Medical Advisory Committee, and QIC. Appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria.

Superior Select is responsible for:
- Requiring consistent application of review criteria for authorization decisions; and
- Consulting with the requesting provider when appropriate.

When applying criteria to members with more complicated conditions, Superior Select will consider the following factors:
- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychological situation; and
- Home environment, when applicable.

Superior Select will also consider characteristics of the local delivery system available for specific members, such as:
- Availability of SNFs, sub-acute care facilities, or home care in Superior Select's service area to support the member after hospital discharge;
- Coverage of benefits for SNFs, sub-acute care facilities, or home care when needed; and
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

When Superior Select's standard UM guidelines and criteria do not apply due to individual patient (member) factors and the available resources of the local delivery system, the Clinical Services staff (review nurse, care manager) will conduct individual case conferences to determine the most appropriate alternative service for that member. The Medical Director may also utilize his or her clinical judgment in completing the service authorization request.

All new medical technology or questionable experimental procedures will require review by the Medical Director prior to approval to establish guidelines where applicable.

Organization Determinations

For all organization determinations, providers may contact Superior Select by mail, phone, or fax.

Superior Select requires prior authorization and/or pre-certification for:

- All non-emergent and non-urgent inpatient admissions
- All non-emergent or non-urgent, out-of network services and

For initial and continuation of services, Superior Select has appropriate mechanisms to ensure consistent application of review criteria for authorization reviews, which include:

- Medical Necessity – approved medical review criteria will be referenced and applied;
- Inter-rater reliability – a process that evaluates the consistency of decisions made by licensed staff when making authorization decisions and ensures the consistent application of medical review criteria; and
- Consultation with the requesting provider when appropriate.

Standard Organization Determination – An organization determination will be made as expeditiously as the member's health condition requires, but no later than 14 calendar days after Superior Select receives the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if Superior Select justifies a need for additional information and documents how the delay is in the interest of the member.

Expedited Organization Determination – A member or any provider may request that
Superior Select expedite an organization determination when the member or his or her provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member's or provider's request. An extension may be granted for 14 additional calendar days if the member requests an extension, or if Superior Select justifies a need for additional information and documents how the delay is in the interest of the member.

Superior Select's organization determination system provides authorization numbers, effective dates for the authorization, and specifies the services being authorized. The requesting provider will be notified verbally via telephone or fax of the authorization.

In the event of an adverse determination, Superior Select will notify the member and the member's representative (if appropriate) in writing and provide written notice to the provider. Written notification to providers will include the UM Department's contact information to allow providers the opportunity to discuss the adverse determination decision. The provider may request a copy of the criteria used for a specific determination of medical necessity by contacting the Clinical Services' UM Department. The member may request a copy of the criteria used for a specific determination of medical necessity by contacting Customer Service.

Reconsideration Requests

Superior Select provides an opportunity for the provider to request a reconsideration of an adverse determination within three business days of the decision. The requesting provider will have the opportunity to discuss the decision with the clinical peer reviewer making the denial determination or with a different clinical peer if the original reviewer cannot be available within one business day of the provider request. Superior Select will respond to the request within one business day.

Emergency Services

Emergency Services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

It is Superior Select's policy that emergency services are covered:

- Regardless of whether services are obtained within or outside the network of providers available;
- Regardless of whether there is prior authorization for the services. In addition:
    - No materials furnished to members (including wallet card instructions) may contain instructions to seek prior authorization for emergency services, and members must be informed of their right to call 911; and
    - No materials furnished to providers, including contracts, may contain instructions to providers to seek prior authorization before the member has been stabilized;
- In accordance with a prudent layperson's definition of "emergency medical condition" regardless of the final medical diagnosis; and
- Whenever a Superior Select provider or other Superior Select representative instructs a member to seek emergency services within or outside the member's Superior Select plan coverage.

Superior Select is not responsible for the care provided for an unrelated non-emergency problem during treatment for an emergency situation. For example, Superior Select is not responsible for any costs such as a biopsy associated with treatment of skin lesions performed by the attending provider who is treating a fracture.

Transition of Care

If a new member has an existing relationship with a provider who is not part of Superior Select's provider network, Superior Select will permit the member to continue an ongoing course of treatment by the non-participating provider during a transitional period.

Superior Select will honor any written documentation of prior authorization of ongoing Covered Services for a period of 30 calendar days (Hawaii: 90 calendar days) after the effective date of enrollment.

For all members, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment with Superior Select:

- Prior existing orders;
- Provider appointments (e.g., dental appointments, surgeries, etc.); and
- Prescriptions (including prescriptions at non-participating pharmacies).

Superior Select cannot delay service authorization if written documentation is not available in a timely manner. Providers may contact the Claims Department for claims payment or claims resolution issues and their Provider Relations representative for rate negotiations.

Members who are inpatient at the time of disenrollment from Superior Select will be covered by Superior Select throughout the acute inpatient stay, however, Superior Select will not be responsible for any discharge needs the member may have.

Superior Select will take immediate action to address any identified urgent medical needs.

Continued Care with a Terminated Provider

When a provider terminates or is terminated without cause, Superior Select will allow members in active treatment to continue either through the completion of their condition (up to 90 calendar days) or until the member selects a new provider.

Superior Select will inform the provider that care provided after termination shall continue under the same terms, conditions and payment arrangements as in the terminated contract.

If a provider is terminated for cause, Superior Select will direct the member immediately to another participating provider for continued services and treatment.

Continuity of Care

Superior Select maintains and monitors a panel of PCPs from which the member may select a personal PCP. All members may select and/or change their PCP to another participating Superior Select Medicare PCP without interference. Superior Select requires members to obtain a referral before receiving specialist services and has a mechanism for assigning PCPs to members who do not select one. Superior Select will also:

- Provide or arrange for necessary specialist care and in particular, give female members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. Superior Select will arrange for specialty care outside of Superior Select's provider network when network providers are unavailable or inadequate to meet a member's medical needs;
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Superior Select utilizes the provision of translator services and interpreter services;
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations;
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services; and
- Have in effect procedures that:
    - Establish and implement a treatment plan that is appropriate;
    - Include an adequate number of direct access visits to specialists;
    - Are time-specific and updated periodically;
    - Facilitate coordination among providers; and
    - Considers the member's input.

Second Opinion

Members have the right to a second surgical/medical opinion in any instance when the member disagrees with his or her provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness. The second surgical/medical opinion, if requested, is to come from a provider chosen by the member who may select:

- A provider that is participating with Superior Select; or
- A non-participating provider located in the same geographical service area of Superior Select, if a participating provider is not available.

If Superior Select's network is unable to provide necessary services to a particular member, Superior Select will adequately and timely cover these services out-of-network for the member for as long as Superior Select is unable to provide them. Superior Select will be financially responsible for a second surgical/medical opinion.

Members must inform their PCP of their desire for a second surgical/medical opinion. If a participating Superior Select provider is selected, the PCP will issue a referral to the member for the visit. If a non-participating provider is required, the PCP will contact Superior Select for authorization.

Any tests that are deemed necessary as a result of the second surgical/medical opinion will be conducted by participating Superior Select providers. The PCP will review the second surgical/medical opinion and develop a treatment plan for the member. If the PCP disagrees with the second surgical/medical opinion request for services, the PCP must still submit the request for services to Superior Select for an organization determination on the recommendation.

The member may file an appeal if Superior Select denies the second surgical/medical opinion provider's request for services. The member may file a grievance if the member wishes to follow the recommendation of the second opinion provider and the PCP does not forward the request for services to Superior Select.

Medicare Quality Healthcare Management (QHCM) Review Process

Superior Select will ensure members receive written notification of termination of service from providers no later than two calendar days before the proposed end of service for SNFs, Home Health Agencies (HHAs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs). The standard *Notice of Medicare Non-Coverage* letter required by CMS will be issued. This letter includes the date coverage of service ends and the process to request an expedited appeal with the QHCM department. Upon notification by QHCM that a member has requested an appeal, Superior Select will issue a *Detailed Explanation of Non-Coverage* which indicates why services are either no longer reasonable or necessary or are no longer covered.

The standardized *Notice of Medicare Non-Coverage* of SNF, HHA and CORF services will be given to the member or, if appropriate, to the member's representative, by the provider of service no later than two (2) calendar days before the proposed end of services. If the member's services are expected to be fewer than two (2) calendar days in duration, the provider should notify the member or, if appropriate, the member's representative, at time of admission. If the services will be rendered in a non-institutional setting and the span of time between the services exceeds two (2) calendar days, the notice should be given no later than two services prior to termination of the service.

Superior Select is financially liable for continued services until two calendar days after the member receives valid notice. A member may waive continuation of services if she or he agrees with being discharged sooner than two calendar days after receiving the notice.

Members who desire a fast-track appeal must submit a request for appeal to the QHCM department, in writing or by telephone, by noon (12 p.m.) of the first day after the day of delivery of the termination notice or, where a member receives the *Notice of Medicare Non-Coverage* more than two calendar days prior to the date coverage is expected to end, by noon (12 p.m.) of the day before coverage ends. Upon notification by QHCM that a member has requested an appeal, Superior Select will issue a *Detailed Explanation of Non-Coverage* which indicates why services are either no longer reasonable or necessary or are no longer covered.

Coverage of provider services continues until the date and time designated on the termination notice, unless the member appeals and QHCM reverses Superior Select's decision.

A member who fails to request an immediate fast-track QHCM review in accordance with these requirements may still file a request for an expedited reconsideration with Superior Select.

Notification of Hospital Discharge Appeal Rights

Prior to discharging a member or lowering the level of care within a hospital setting, Superior Select will secure concurrence from the provider responsible for the member's inpatient care.

Superior Select will ensure members receive a valid written notification of termination of inpatient services from the facility according to the guidelines set by Medicare. Hospitals must issue the *Important Message* within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge. This letter will include the process to request an immediate review with QHCM.

Members who desire an immediate review must submit a request to QHCM, in writing or by telephone, by midnight (12 a.m.) of the day of discharge. The request must be submitted before the member leaves the hospital.

If the member fails to make a timely request to QHCM, she or he may request an expedited reconsideration by Superior Select.

Upon notification by QHCM that a member has requested an immediate review, Superior Select will contact the facility, request all relevant medical records, a copy of the executed IM, and evaluate for validity. If after review, Superior Select concurs that the discharge is warranted, Superior Select will issue a *Detailed Notice of Discharge* providing a detailed reason why services are either no longer reasonable, necessary or are no longer covered.

Coverage of inpatient services continues until the date and time designated on the *Detailed Notice of Discharge*, unless the member requests an immediate QHCM review. Liability for further inpatient hospital services depends on the QHCM decision.

If QHCM determines that the member did not receive valid notice, coverage of inpatient services by Superior Select continues until at least two calendar days after valid notice has been received. Continuation of coverage is not required if QHCM determines that the coverage could pose a threat to the member's health or safety.

The burden of proof lies with Superior Select to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. To meet this burden, Superior Select must supply any and all information that QHCM requires to sustain Superior Select's decision.

Superior Select is financially responsible for coverage of services, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

If QHCM reverses Superior Select's termination decision, Superior Select must provide the member with a new notice when the hospital or Superior Select once again determines that the member no longer requires acute inpatient hospital care.

Availability of Utilization Management Staff

Superior Select's Clinical Services Department provides medical and support staff resources, including a Medical Director, to process requests and provide information for the routine or urgent authorization/pre-certification of services, utilization management functions, provider questions, comments or inquiries.

Care Management Program

Overview

Superior Select offers comprehensive care management services to facilitate patient assessment, planning and advocacy to improve health outcomes for patients. Superior Select trusts providers will help coordinate the placement and cost-effective treatment of patients who are eligible for Superior Select's Care Management Programs. For specific information on Care Management programs for dual-eligible members, or Model of Care, see *Section 10: Dual-Eligible Members* in this Manual.

Superior Select's Care Management teams are led by specially trained registered nurse and licensed clinical social worker care managers who assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

The care managers work collaboratively with PCPs and specialists to coordinate care for the member and expedite access to care and needed services.

Superior Select's Care Management teams also serve in a support capacity to the PCP and assist in actively linking the member to providers, medical services, residential, social and other support services, as needed. Providers may request care management services for any member.

The care management process begins with member identification and follows the member until discharge from the Program. Members may be identified for care management in various ways, including:

- A referral from a member's PCP;
- Self-referral;
- Referral from a family member;
- After completing a Health Risk Assessment; and
- Data mining for members with high utilization.

Superior Select's philosophy is that the Care Management Program is an integral management tool in providing a continuum of care for members. Key elements of the care management process include:

- **Clinical Assessment and Evaluation** – a comprehensive assessment of the member is completed to determine where she or he is in the health continuum. This assessment gauges the member's support systems and resources and seeks to align them with appropriate clinical needs;
- **Care Planning** – collaboration with the member and/or caregiver as well as the PCP to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the provider's plan of care;

- **Service Facilitation and Coordination** – working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up; and
- **Member Advocacy** – advocating on behalf of the member within the complex labyrinth of the health care system. Care managers assist members with seeking the services to optimize their health. Care management emphasizes continuity of care for members through the coordination of care among physicians and other providers.

Superior Select's Care Management Program may include members with:

- **Catastrophic Injuries** – such as head injury, near drowning, burns;
- **Multiple Chronic Conditions** – multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple barriers to quality health care (i.e., Acquired Immune Deficiency Syndrome (AIDS));
- **Transplantation** – organ failure, donor matching, post-transplant follow-up; and
- **Complex Discharge Needs** - members discharged home from acute inpatient or SNF with multiple service and coordination needs (i.e., DME, PT/OT, home health); complicated, non-healing wounds, advanced illness, etc.

Section 5: Claims

Overview

The focus of the Claims Department is to process claims in a timely manner. Superior Select has established toll-free telephone numbers for providers to access a representative in the Customer Service Department.

Timely Claims Submission

Unless otherwise stated in the Agreement, providers must submit clean claims (initial, corrected and voided) to Superior Select within 90 calendar days (unless other timely filing has been agreed) from the date of discharge for inpatient services or the date of service for all other services. The start date for determining the timely filing period is the "from" date reported on a CMS-1500 or 837-P for professional claims or the "through" date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or CMS, Superior Select may deny payment of any claim that fails to meet Superior Select's submission requirements for clean claims or failure to timely submit a clean claim to Superior Select.

Please note that claims filed by providers who are not part of the network must be filed no later than 12 months, or one calendar year, after the date the services were furnished.

The following items can be accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Superior Select; and
- A provider's electronic submission sheet that contains all the following identifiers:
    - Patient name;
    - Provider name;
    - Date of service to match Explanation of Benefits (EOB)/claim(s) in question;
    - Prior submission bill dates; and
    - Superior Select's product name or line of business.

The following items are examples of what is not acceptable as evidence of timely submission: • Strategic National Implementation Process (SNIP) Rejection Letter; and

- A copy of the provider's billing screen.

Tax ID and National Provider Identifier Requirements

Superior Select requires the payer-issued Tax Identification Number (Tax ID / TIN) and National Provider Identifier (NPI) on all claims submissions, with the exception of atypical providers. Atypical providers must pre-register with Superior Select before submitting claims to avoid NPI rejections. Superior Select will reject claims without the Tax ID and NPI. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996's (HIPAA) NPI Final Rule Administrative Simplification, is available on the CMS website at **http://www.cms.gov**.

Taxonomy
Providers are encouraged to submit claims with the correct taxonomy code consistent with provider's specialty and services being rendered in order to increase appropriate adjudication. Superior Select may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted.

Preauthorization number
If a preauthorization number was obtained, the provider must include this number in the appropriate data field on the claim.

National Drug Codes
Superior Select follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit National Drug Codes as required by CMS.

Strategic National Implementation Process
All claims and encounter transactions submitted via paper, direct data entry (DDE), or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines.

If a claim is rejected for lack of compliance with Superior Select's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits. For more information on encounters, see the *Encounters Data* section below.

Claims Submission Requirements

Providers using electronic submission shall submit clean claims to Superior Select or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/ UB-04 (or their successors), as applicable. Claims shall include the provider's NPI, tax ID and the valid taxonomy code that most accurately describes the services reported on the claim. The provider acknowledges and agrees that no reimbursement or compensation is due for a Covered Service, and no claim is complete for a Covered Service, unless performance of that Covered Service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. The provider also acknowledges and agrees that at no time shall members be responsible for any payments to the provider with the exception of member expenses or non-covered services.

Electronic Claims Submissions
Superior Select accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Superior Select must be in the ANSI ASC X12N format, version 5010A, or its successor.

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, or the clearinghouses Superior Select uses to establish EDI with Superior Select. For a list of clearinghouses Superior Select uses, for information on the Superior Select's unique payer identification numbers used to identify Superior Select on electronic claims submissions, or to contact Superior Select's Claims Department.

HIPAA Electronic Transactions and Code Sets
HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as Superior Select, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

To promote consistency and efficiency for all claims and encounter submissions to Superior Select, it is Superior Select's policy that these requirements apply to all paper and DDE transactions.

Paper Claims Submissions
Providers are encouraged to submit claims to Superior Select electronically.

If permitted under the Agreement and until the provider has the ability to submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- All paper claims must be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.
- Per CMS guidelines, the following process should be used for clean claims submission:
- The information must be aligned within the data fields and must be:
    - On an original red-ink-on-white paper claim form;
    - Typed. Do not print, hand-write, or stamp any extraneous data on the form;
    - In black ink;
    - Large, dark font such as, PICA or ARIAL, and 10-, 11- or 12-point type; and
    - In capital letters.

    The typed information must not have:

    - Broken characters;
    - Script, italics or stylized font;
    - Red ink;
    - Mini font; or
    - Dot matrix font.

CMS Fact Sheet about UB-04
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ub04_fact_sheet.pdf

CMS Fact Sheet about CMS-1500
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf

Claims Processing

Readmission
Superior Select may choose to review claims if data analysis deems it appropriate. Superior Select may review hospital admissions on a specific member if it appears that two or more admissions are related based on the data analysis. Based upon the claim review (including a review of medical records if requested from the provider) Superior Select will make all necessary adjustments to the claim, including recovery of payments which are not supported by the medical record. Superior Select may recoup overpayments from providers who do not submit the requested medical records or who do not remit the overpayment amounts identified by Superior Select.

Three Day Payment Window
Superior Select follows the CMS guidelines for outpatient services treated as inpatient services (including but not limited to: outpatient services followed by admission before midnight of the following day, preadmission diagnostic services, and other preadmission services). Please refer to the CMS *Medicare Claims Processing Manual* for additional information.

Disclosure of Coding Edits
Superior Select uses claims editing software programs to assist in determining proper coding for provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule Database, the American Medical Association (AMA) and Specialty Society correct coding guidelines, and state-specific regulations. These software programs may result in claim edits for specific procedure code combinations. They may also result in adjustments to the provider's claims payment or a request for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these claims editing software programs by submitting a timely request for reconsideration to Superior Select. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Prompt Payment
Superior Select will pay clean claims in accordance with the terms of the Agreement.

Rate Updates
Superior Select implements and prospectively applies changes to its fee schedules and CMS's changes to Medicare fee schedules as of the later of:

- The effective date of the change; or
- 45 days from the date CMS publishes the change on its website.

Superior Select will not retrospectively apply increases or decreases in rates to claims that have already been paid.

Coordination of Benefits (COB)
Superior Select shall coordinate payment for Covered Services in accordance with the terms of a member's benefit plan, applicable state and federal laws, and CMS guidance. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Superior Select. Any balance due after receipt of payment from the primary payer should be submitted to Superior Select for consideration and the claim must include information verifying the payment amount received from the primary. COB information can be submitted to Superior Select by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the EOB. Superior Select may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services to the extent permitted by applicable laws. Providers shall follow Superior Select's policies and procedures regarding subrogation activity.

Encounters Data

Overview

This section is intended to give providers necessary information to allow them to submit encounter data to Superior Select. If encounter data do not meet the requirements set forth in Superior Select's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (e.g., CMS) have the ability to impose significant financial sanctions on Superior Select. Superior Select requires all delegated vendors, delegated providers, and capitated providers to submit encounter data to Superior Select, even if they are reimbursed through a capitated arrangement.

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP levels 1 through 5 shall be maintained. Once Superior Select receives a provider's encounters, the encounters are loaded into Superior Select's encounters system and processed. The encounters are subjected to a series of SNIP editing to ensure that the encounter has all the required information and that the information is accurate.

Vendors are required to comply with any additional encounters validations as defined by CMS.

Encounters Submission Methods

Delegated providers may submit encounters electronically, through Superior Select's contracted clearinghouse(s), or using Superior Select's Secure File Transfer Protocol (SFTP) process.

Submitting Encounters Using SFTP Process (*Preferred Method*)

Superior Select accepts electronic claims submission through EDI as its preferred method of claims submission. Encounters may be submitted using Superior Select's SFTP and process. Refer to Superior Select's ANSI ASC X12 837I, 837P, and 837D Health Care Claim / Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP.

Encounters Data Types

There are four encounter types for which delegated vendors and providers are required to submit encounter records to Superior Select. Encounter records should be submitted using the HIPAA-standard transactions for the appropriate service type. The four encounter types are:

- Dental – 837D format;
- Professional – 837P format;
- Institutional – 837I format; and
- Pharmacy – NCPDP format.

This document is intended to be used in conjunction with Superior Select's ANSI ASC X12 837I, 837P, and 837D Health Care Claim / Encounter Institutional, Professional, and Dental Guides.

Encounters submitted to Superior Select from a delegated provider can be a new, voided or replaced / overlaid encounter. The definitions of the types of encounters are as follows:

- New Encounter – An encounter that has never been submitted to Superior Select previously.

- Voided Encounter – An encounter that Superior Select deletes from the encounter file and is not submitted to the state.
- Replaced or Overlaid Encounter – An encounter that is updated or corrected within the system.

Member Expenses and Maximum Out-of-Pocket

The provider is responsible for collecting member expenses. Providers are not to bill members for missed appointments, administrative fees or other similar type fees. If a provider collects member expenses determined to exceed the member's responsibility, the provider must reimburse the member the excess amount. The provider may determine an excess amount by referring to the Explanation of Payment (EOP).

For certain benefit plans, member expenses are limited by a maximum out-of-pocket amount. For more information on maximum out of pocket amounts, and responsibilities of a provider of care to a Medicare member, refer to *Section 2: Provider and Member Administrative Guidelines.*

Provider-Preventable Conditions

Superior Select follows CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- A different procedure altogether;
- The correct procedure but on the wrong body part; or
- The correct procedure on the wrong patient.

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/ index.html** and include such events as an air embolism, falls, and catheter-associated urinary tract infection.

Health care providers may not bill, attempt to collect from, or accept any payment from Superior Select or the member for PPCs or hospitalizations and other services related to these noncovered procedures.

Reopening and Revising Determinations

A reopening request must be made in writing, clearly stating the specific reason for requesting the reopening. It is the responsibility of the provider to submit the requested documentation within 90 days of the denial to re-open the case.

All decisions to grant reopening are at the discretion of Superior Select. See the *Medicare Claims Processing Manual*, Chapter 34, for Reopening and Revision of Claim Determinations and Decisions guidelines.

Disputed Claims

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Superior Select in writing within 90 calendar days of the date of denial of the EOP for participating providers and within 180 days of the date of denial of the EOP for non-participating providers.

Please provide the following information on the written provider dispute:

- Date(s) of service;
- Member name;
- Member ID number and/or date of birth;
- Provider name;
- Provider Tax ID / TIN;
- Total billed charges;
- The provider's statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g. proof of timely filing, medical records).

Corrected or Voided Claims

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines.

To submit a corrected or voided claim electronically:

- For Institutional claims, the provider must include Superior Select's original claim number for the claim adjusting or voiding in the REF*F8 (loop and segment) for any 7 (replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837 layout.
- For Professional claims, the provider must have the Frequency Code marked appropriately as 7 (Replacement for prior claim) or 8 (void/cancel of prior claim) in the standard 837 layout.

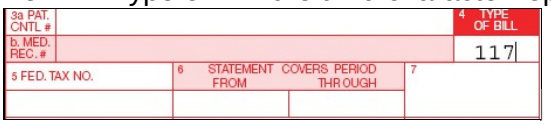
These codes are not intended for use for original claim submission or rejected claims.

To submit a corrected or voided claim via paper:

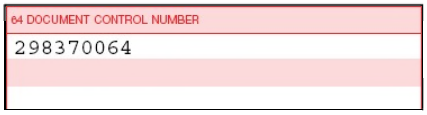
- For Institutional claims, the provider must include Superior Select's original claim number and bill the frequency code per industry standards.

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"



Box 64 – Place the claim number of the prior claim in Box 64



- For Professional claims, provider must include Superior Select's original claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified in the left-hand side of Box 22.

Example:

Any missing, incomplete or invalid information in any field may cause the claim to be rejected.

Please note: If "corrected claim" is handwritten, stamped or typed on the claim form without the appropriate Frequency Code "7" or "8" along with the Original Reference Number as indicated above, the claim will be considered an original first-time claim submission.

The correction or void process involves two transactions:

1. The original claim will be negated – paid or zero payment (zero net amount due to a copayment, coinsurance or deductible) – and noted "*Payment lost/voided/missed*." This process will deduct the payment for this claim, or zero net amount if applicable.
2. The corrected or voided claim will be processed with the newly submitted information and noted "*Adjusted per corrected bill*." This process will pay out the newly calculated amount on this corrected or voided claim with a new claim number.

The payment reversal for this process may generate a negative amount, which will be seen on a later EOP than the EOP that is sent out for the newly submitted corrected claim.

Reimbursement

Superior Select applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

Surgical Payments

Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications** - A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by Superior Select's Medical Director regarding whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination** - One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges** - Charges for follow-up surgery visits are considered to be included in the surgical service charge and providers should not submit a claim for such visits and providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures** - Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon** - Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies. Superior Select uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes", CMS is used as the secondary source.
- **Co-Surgeon** - Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct, operative work, by adding the appropriate

modifier to the procedure code and any associated addon code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.

Modifiers
Superior Select follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Medicare Overpayment Recovery

Superior Select strives for 100% payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur due to reasons such as retroactive member termination, inappropriate coding, duplication of payments, nonauthorized services, erroneous contract or fee schedule reimbursement, non-covered benefit(s) and other reasons.

Superior Select will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, Superior Select will follow the same methodology used by the CMS Recovery Audit Contractor (RAC) program by limiting its recovery to three (3) years from the date of service. In all cases, Superior Select, or its designee, will provide a written notice to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. If the overpayment results from coordination of benefits, the written notice will specify the name of the carrier and coverage period for the member. The notice will also provide the carrier address Superior Select has on file but recognizes that the provider may use the carrier address it has on file. The standard request notification provides forty-five (45) calendar days for the provider to send in the refund, request further information or dispute the overpayment. For more information on the CMS RAC, refer to the CMS website.

Failure of the provider to respond within the above timeframes will constitute acceptance of the terms in the letter and will result in offsets to future payments. The provider will receive an Explanation of Payment (EOP) indicating if the balance has been satisfied. In situations where the overpaid balance has aged more than three (3) months, the provider may be contacted by Superior Select, or its designee, to arrange payment.

If the provider independently identifies an overpayment, they can either (a) send a corrected claim (refer to the corrected claim section of the manual); (b) contact Superior Select Finance to arrange an off-set against future payments; or (c) send a refund and explanation of the overpayment to:

Superior Select Plan
Finance Department – Attn: Claims
PO Box 3630
Little Rock, AR 72204

Benefits During Disaster and Catastrophic Events

In the event of a presidential emergency declaration, a presidential (major) disaster declaration, a declaration of emergency or disaster by a governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary – Superior Select will:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified noncontracted facilities (note that Part A/B benefits must, per 42 CFR 422.204(b)(3), be furnished at Medicare-certified facilities);
- Waive in full, requirements for authorization or pre-notification;
- Temporarily reduce Superior Select-approved out-of-network cost sharing to in-network cost sharing amounts; and/or
- Waive the 30-calendar-day notification requirement to members as long as all the changes (such as reduction of cost sharing and waiving authorization) benefit the member.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency timeframe has not been closed 30 calendar days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, Superior Select should resume normal operations 30 calendar days from the initial declaration.

Type of Claim	Modifier
An institutional claim	*Condition Code* will be DR or Modifier CR
A professional claim	*Modifier* will be CR Code

Section 6: Credentialing

Overview

Credentialing is the process by which the appropriate Superior Select peer review bodies evaluate the credentials and qualifications of practitioners including physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations. For purposes of *Section 6: Credentialing* in this Manual, all references to "practitioners" shall include providers providing health or health-related services including the following: physicians, allied health professionals, hospitals, surgery centers, home health agencies, skilled nursing facilities and other ancillary facilities/health care delivery organizations.

This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Work history and demonstrated ability;
- Patient admitting capabilities;
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

Practitioners are required to be credentialed prior to being listed as a Superior Select-participating network provider of care or services to its members.

The Credentialing Department, or its designee, is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and asks for information regarding professional liability claims history and suspension or restriction of hospital privileges, criminal history, licensure, Drug Enforcement Administration (DEA) certification, or Medicare/Medicaid sanctions.

Please take note of the following credentialing process highlights:

- Primary source verifications are obtained in accordance with state and federal regulatory agencies, accreditation, and Superior Select policy and procedure requirements, and include a query to the National Practitioner Data Bank.
- Physicians, allied health professionals, and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to Superior Select members.
- Satisfactory site inspection evaluations may be required to be performed in accordance with state and federal accreditation requirements.
- After the credentialing process has been completed, a timely notification of the credentialing decision is forwarded to the provider.

Credentialing may be done directly by Superior Select or by an entity approved by Superior Select for delegated credentialing. In the event that credentialing is delegated to an outside agency, the agency shall

be required to meet Superior Select's criteria to ensure that the credentialing capabilities of the delegated entity clearly meet federal and state accreditation (as applicable) and Superior Select requirements.

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures, credentialing forms, and files.

Practitioner Rights

Practitioner Rights are listed below and are included in the application/re-application cover letter.

Practitioner's Right to Be Informed of Credentialing/Re-Credentialing Application Status Written requests for information may be emailed to **networkops@superiorselectinc.com** . Upon receipt of a written request, Superior Select will provide written information to the practitioner on the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items pending verification, needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared with the information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/ ReCredentialing Application

The practitioner may review documentation submitted by him or her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any Superior Select restrictions. Superior Select, or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for provider network participation or re-credentialing.

The provider may not review peer review information obtained by Superior Select.

Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by Superior Select, the practitioner has the right to review the information that was submitted in support of his or her application, and has the right to correct the erroneous information. Superior Select will provide written notification to the practitioner of the discrepant information.

Superior Select's written notification to the practitioner will include:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The timeframe for submitting the corrections;
- The addressee in the Credentialing Department to whom corrections must be sent;
- Superior Select's documentation process for receiving the correction information from the provider; and
- Superior Select's review process.

Baseline Criteria

Baseline criteria for practitioners to qualify for provider network participation:

License to Practice – Practitioners must have a current, valid, unrestricted license to practice.

Drug Enforcement Administration Certificate – Practitioners must have a current valid DEA Certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).

Work History – Practitioners must provide a minimum of five years' relevant work history as a health professional.

Board Certification – Physicians (M.D., D.O., D.P.M.) must maintain Board Certification in the specialty being practiced as a provider for Superior Select, or must have verifiable educational/training from an accredited training program in the specialty requested.

Hospital-Admitting Privileges – Specialist practitioners shall have hospital-admitting privileges at a Superior Select-participating hospital (as applicable to specialty). PCP's may have hospital admitting privileges or may enter into a formal agreement with another Superior Select-participating provider who has admitting privileges at a Superior Select-participating hospital, for the admission of members.

Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in any Superior Select plan. Existing providers who are sanctioned, and thereby restricted from participation in any government program, are subject to immediate termination in accordance with Superior Select policy and procedure and the Agreement.

Providers who Opt-Out of Medicare – A provider who opts out of Medicare is not eligible to become a participating provider. An existing provider who opts out of Medicare is not eligible to remain as a participating provider for Superior Select. At the time of initial credentialing, Superior Select reviews the state-specific opt-out listing maintained on the designated state carrier's website to determine whether a provider has opted out of Medicare. The opt-out website is monitored on an ongoing/quarterly basis by Superior Select.

Liability Insurance

Superior Select providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Superior Select in writing.

Providers must furnish copies of current professional liability insurance certificate to Superior Select, concurrent with expiration.

Site Inspection Evaluation

Site Inspection Evaluations (SIEs) may be conducted, and would be in accordance with federal, state and accreditation requirements. Focusing on quality, safety, and accessibility, performance standards and thresholds were established for:

- Office-site criteria:
- Physical accessibility;
- Physical appearance;
- Adequacy of waiting room and examination room space; and
- Medical / treatment record keeping criteria.

SIEs are conducted for:

- Unaccredited facilities;
- State-specific initial credentialing requirements;
- State-specific re-credentialing requirements; and
- When complaint is received relative to office site criteria.

In those states where initial SIEs are not a requirement for credentialing, there is ongoing monitoring of member complaints. SIEs are conducted for those sites where a complaint is received relative to office site criteria listed above. SIEs may be performed for an individual complaint or quality of care concern if the severity of the issue is determined to warrant an onsite review.

Covering Physicians

Primary care physicians in solo practice must have a covering physician who also participates with, or is credentialed with, Superior Select.

Allied Health Professionals

Allied Health Professionals (AHPs), both dependent and independent, are credentialed by Superior Select.

Dependent AHPs include the following, and are required to provide collaborative practice information to Superior Select:

- ARNPs;
- Certified Nurse Midwives (CNM);
- PAs; and
- Osteopathic Assistants (OA).

Independent AHPs include, but are not limited to the following:

- Licensed clinical social workers;
- Licensed behavioral health counselors;
- Licensed marriage and family therapists;
- Physical therapists;
- Occupational therapists;
- Audiologists; and
- Speech/language therapists/pathologists.

Ancillary Health Care Delivery Organizations

Ancillary and organizational applicants must complete an application and, as applicable, undergo an SIE if unaccredited. Superior Select is required to verify accreditation, licensure, Medicare certification (as applicable), regulatory status and liability insurance coverage, prior to accepting the applicant as a Superior Select participating provider.

Re-Credentialing

In accordance with regulatory, accreditation, and Superior Select policy and procedure, re-credentialing is required at least once every three years.

Updated Documentation

In accordance with the Agreement, providers should furnish copies of current professional or general liability insurance, license, DEA certificate and accreditation information (as applicable to provider type) to Superior Select, prior to or concurrent with expiration.

Office of Inspector General Medicare/Medicaid Sanctions Report

On a regular and ongoing basis, Superior Select or its designee accesses the listings from the Office of Inspector General (OIG) Medicare/Medicaid Sanctions (exclusions and reinstatements) Report, for the most current available information. This information is cross-checked against Superior Select's network of providers. If participating providers are identified as being currently sanctioned, such providers are subject to immediate termination, in accordance with Superior Select policies and procedures and the Agreement.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a regular and ongoing basis, Superior Select, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned providers. This information is crosschecked against the network of Superior Select providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Superior Select policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Superior Select policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

Participating Provider Appeal through the Dispute Resolution Peer Review Process

Superior Select may immediately suspend, pending investigation, the participation status of a provider who, in the sole opinion of Superior Select's Medical Director, is engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members.

Superior Select has a Participating Provider Dispute Resolution Peer Review Panel process in the event Superior Select chooses to alter the conditions of participation of a provider based on issues of quality of care, conduct or service, and if such process is implemented, may result in reporting to regulatory agencies.

The Provider Dispute Resolution Peer Review process has two levels. All disputes in connection with the actions listed below are referred to a first level Peer Review Panel consisting of at least three qualified individuals of whom at least one is a participating provider and a clinical peer of the practitioner that filed the dispute.

The practitioner also has the right to consideration by a second-level Peer Review Panel consisting of at least three qualified individuals of which at least one is a participating provider and a clinical peer of the practitioner that filed the dispute and the second-level panel is comprised of individuals who were not involved in earlier decisions.

The following actions by Superior Select entitle the practitioner affected thereby to the Provider Dispute Resolution Peer Review Panel Process:

- Suspension of participating practitioner status for reasons associated with clinical care, conduct, or service;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct, or service; or
- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct, service, or excessive claims and/or sanction history.

Notification of the adverse recommendation, together with reasons for the action, the practitioner's rights, and the process for obtaining the first and or second level Dispute Resolution Peer Review Panel, are provided to the practitioner. Notification to the practitioner will be mailed by an overnight carrier or certified mail, with return-receipt requested.

The practitioner has 30 days from the date of Superior Select's notice to submit a written request to Superior Select. This request must be sent by a nationally recognized overnight carrier or U.S. certified mail, with return receipt, to invoke the Dispute Resolution Peer Review Panel process.

Upon Superior Select's timely receipt of the request, Superior Select's Medical Director or his or her designee shall notify the practitioner of the date, time, and telephone access number for the Panel hearing. Superior Select then notifies the practitioner of the schedule for the Review Panel hearing.

The practitioner and Superior Select are entitled to legal representation at the Review Panel hearing. The practitioner has the burden of proof by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis, or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable, or capricious.

The Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. Superior Select's Medical Director, within five business days after final adjournment of the Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the first level Panel hearing. In the event the findings are positive for the practitioner, the second-level panel review shall be waived.

In the event the findings of the first-level Panel hearing are adverse to the practitioner, the practitioner may access the second-level Peer Review Panel by following the notice information contained in the letter notifying the practitioner of the adverse determination of the first-level Peer Review Panel.

Within 10 calendar days of the request for a second-level Peer Review Panel hearing, the Medical Director or her or his designee shall notify the practitioner of the date, time, and access number for the second-level Peer Review Panel hearing.

The second-level Dispute Resolution Peer Review Panel shall consider and decide the case objectively and in good faith. The Medical Director, within five business days after final adjournment of the second-level Dispute Resolution Peer Review Panel hearing, shall notify the practitioner of the results of the second-level Panel hearing via certified or overnight recorded delivery mail. The findings of the second-level Peer Review Panel shall be final.

A practitioner who fails to request the Provider Dispute Resolution Peer Review Process within the time and in the manner specified waives all rights to such review to which he or she might otherwise have been entitled. Superior Select may terminate the practitioner and make the appropriate report to the National Practitioner Data Bank and State Licensing Agency as appropriate and if applicable.

Delegated Entities

All participating providers or entities delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a monthly/quarterly basis and formal audits are conducted annually. Please refer to *Section 9: Delegated Entities* of this Manual for further details.

Section 7: Reconsiderations (Appeals) and Grievances

Appeals

Provider Retrospective Appeals Overview

A provider may appeal a claim or utilization review denial on his or her own behalf by mailing or faxing Superior Select a letter of appeal or an appeal form with supporting documentation such as medical records. Appeal forms are located on Superior Select's website at www.superiorselectMedicare.com

Providers have 90 calendar days from Superior Select's original utilization management review decision or claim denial to file a provider appeal. Appeals after that time will be denied for untimely filing. If the provider feels that the appeal was filed within the appropriate timeframe, the provider may submit documentation showing proof of timely filing. The only acceptable proof of timely filing is a registered postal receipt signed by a representative of Superior Select, or a similar receipt from other commercial delivery services.

Upon receipt of all required documentation, Superior Select has up to 45 calendar days to review the appeal for medical necessity and conformity to Superior Select guidelines and to render a decision to reverse or affirm. Required documentation includes the member's name and/or identification number, date of services, and reason why the provider believes the decision should be reversed. Additional required information varies based on the type of appeal being requested. For example, if the provider is requesting a medical necessity review, medical records should be submitted. If the provider is appealing a denial based on untimely filing, proof of timely filing should be submitted. If the provider is appealing the denial based on not having a prior authorization, then documentation regarding why the service was rendered without prior authorization must be submitted.

Appeals received without the necessary documentation will not be reviewed by Superior Select due to lack of information. It is the responsibility of the provider to provide the requested documentation within 60 calendar days of the denial to review the appeal. Records and documents received after that time will not be reviewed and the appeal will remain closed.

Medical records and patient information shall be supplied at the request of Superior Select or appropriate regulatory agencies when required for appeals. The provider is not allowed to charge Superior Select or the member for copies of medical records provided for this purpose.

Provider Retrospective Appeals Decisions

Reversal of Initial Denial

If it is determined during the review that the provider has complied with Superior Select protocols and that the appealed services were medically necessary, the initial denial will be reversed. The provider will be notified of this decision in writing.

The provider may file a claim for payment related to the appeal, if one has not already been submitted. After the decision to reverse the denial has been made, any claims previously denied will be adjusted for payment. Superior Select will ensure that claims are processed and comply with federal and state requirements, as applicable.

Affirmation of Initial Denial
If it is determined during the review that the provider did not comply with Superior Select protocols and/or medical necessity was not established, the initial denial will be upheld. The provider will be notified of this decision in writing.

For denials based on medical necessity, the criteria used to make the decision will be provided in the letter. The provider may also request a copy of the clinical rationale used in making the appeal decision by sending a written request to the appeals address listed in the decision letter.

Member Reconsideration Process

Overview
A member reconsideration, also known as an appeal, is a formal request from a member for a review of an action taken by Superior Select. A reconsideration may also be filed the member's behalf by an authorized representative or a provider with the member's written consent. All appeal rights described in *Section 7* of this Manual that apply to members will also apply to the member's authorized representative or a provider acting on behalf of the member with the member's consent.

To request an appeal of a decision made by Superior Select, a member may file a reconsideration request orally or in writing within 60 days from the date of the Notice of Action. If the member's request is made orally, Superior Select will mail an acknowledgment letter to the member to confirm the facts and basis of the appeal.

Examples of actions that can be appealed include, but are not limited to:
- 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; and/or
- The failure to provide services in a timely manner, as defined by CMS.

Superior Select gives members reasonable assistance in completing forms and other procedural steps for a reconsideration, including but not limited to providing interpreter services and toll-free telephone numbers with TTY/TDD and interpreter capability.

Superior Select ensures that decision-makers assigned to reconsiderations were not involved in reconsiderations of previous levels of review. When deciding a reconsideration based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues, the reviewers will be health care professionals with clinical expertise in treating the member's condition/disease or will seek advice from providers with expertise in the field of medicine related to the request.

Superior Select will not retaliate against any provider acting on behalf of or in support of a member requesting a reconsideration or an expedited reconsideration.

Types of Appeals
A member may request a standard pre-service, retrospective, or an expedited appeal.

Standard pre-service appeals are requests for services that Superior Select has determined are not Covered Services, are not medically necessary, or are otherwise outside of the member's benefit plan.

Retrospective, or post-service, appeals are typically requests for payment for care or services that the member has already received. Accordingly, a retrospective appeal would never result in the need for an expedited review. These are the only appeals that may be made by the provider on his or her own behalf.

Only pre-service appeals are eligible to be processed as expedited appeals.

Appeal Decision Timeframes
Superior Select will issue a decision to the member or the member's representative within the following timeframes:

- Standard Pre-Service Request: **30 calendar days**
- Retrospective Request: **60 calendar days**
- Expedited Request: **72 hours**

Standard Pre-Service and Retrospective Reconsiderations
A member may file a reconsideration request either verbally or in writing within 60 calendar days of the date of the adverse determination by contacting the Customer Service Department.

A member may also present his or her appeal in person. To do so, the member must call Superior Select to advise that the member would like to present the reconsideration in-person or via the telephone. If the member would like to present her or his appeal in-person, Superior Select will arrange a time and date that works best for the member and Superior Select. A member of the management team and a Superior Select Medical Director will participate in the in-person appeal.

After the member presents the information, Superior Select will mail the decision to the member within the timeframe specified above, based on the type of appeal.

If the member's request for reconsideration is submitted after 60 calendar days, then good cause must be shown in order for Superior Select to accept the late request. Examples of good cause include, but are not limited to:

- The member did not personally receive the adverse organization determination notice or received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accident caused important records to be destroyed;
- Documentation was difficult to locate within the time limits; and/or
- The member had incorrect or incomplete information concerning the reconsideration process.

Expedited Reconsiderations
To request an expedited reconsideration, a member or a provider (regardless of whether the provider is affiliated with Superior Select) must submit a verbal or written request directly to Superior Select. A request to expedite a reconsideration of a determination will be considered in situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function, including cases in which Superior Select makes a less than fully favorable decision to the member.
A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.

If a reconsideration is expedited, Superior Select will complete the expedited reconsideration and give the member (and the provider involved, as appropriate) notice of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving a valid and complete request for reconsideration.

If Superior Select denies the request to expedite a reconsideration, Superior Select will provide the member with verbal notification within 24 hours. Within three calendar days of the verbal notification, Superior Select will mail a letter to the member explaining:

- That Superior Select will automatically process the request using the 30 calendar day timeframe for standard reconsiderations;
- The member's right to file an expedited grievance if he or she disagrees with Superior Select's decision not to expedite the reconsideration and provides instructions about the expedited grievance process and its timeframes; and
- The member's right to resubmit a request for an expedited reconsideration and that if the member gets any provider's support indicating that applying the standard timeframe for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function, the request will be expedited automatically.

Member Reconsideration Decisions

Reconsideration Levels

There are five levels of reconsideration available to Medicare beneficiaries enrolled in Medicare Advantage plans after an adverse organization determination has been made. These levels will be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of adverse organization determination by Superior Select;
2. Reconsideration of adverse organization determination by the Independent Review Entity (IRE);
3. Hearing by an Administrative Law Judge (ALJ), if the appropriate threshold requirements set forth in §100.2 have been met;
4. Medicare Appeals Council (MAC) Review; and
5. Judicial Review, if the appropriate threshold requirements have been met.

Standard Pre-Service or Retrospective Reconsideration Decisions

If Superior Select reverses its initial decision, Superior Select will either issue an authorization for the preservice request or send payment if the service has already been provided.

If Superior Select affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 30 days from receipt of the appeal to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and Superior Select. In the event the IRE agrees with Superior Select, the IRE will provide the member further appeal rights.

If the IRE reverses the initial denial, the IRE will notify the member or representative in writing of the decision. Superior Select will also notify the member or member's representative in writing that the services are approved along with an authorization number.

Expedited Reconsideration Decisions
If Superior Select reverses its initial action and/or the denial, it will notify the member verbally within 72 hours of receipt of the expedited appeal request followed with written notification of the appeal decision.

If Superior Select affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the independent review entity (IRE) contracted by CMS. The IRE has 72 hours from receipt of the case to issue a final determination; and
- Notify the member of the decision to affirm the initial denial and that the case has been forwarded to the IRE.

Once a final determination has been made, the IRE will notify the member and Superior Select. In the event the IRE agrees with Superior Select, the IRE will provide the member further appeal rights. If the IRE reverses the initial denial, the IRE notifies the member or representative in writing of the decision.

Grievances

Provider
Medicare Advantage providers are not able to file a grievance per CMS guidance.

Member Grievance Overview
The member may file a grievance. A grievance may also be filed on the member's behalf by an authorized representative or a provider with the member's written consent. All grievance rights described in *Section 7* of this Manual that apply to members will also apply to the member's authorized representative or a provider acting on behalf of the member with the member's consent. If the member wishes to use a representative, then she or he must complete a *Medicare Appointment of Representative* (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. The form is located on Superior Select's website at www.superiorselectMedicare.com.

Examples of issues that may result in a grievance include, but are not limited to:

- Provider Service including, but not limited to:
  - Rudeness by provider or office staff;
  - Refusal to see member (other than in the case of patient discharge from office); or
  - Office conditions.
- Services provided by Superior Select including, but not limited to:
  - Hold time on telephone; o Rudeness of staff;
  - Involuntary disenrollment from Superior Select; or
  - Unfulfilled requests.
- Access availability including, but not limited to:
  - Difficulty getting an appointment;

- o Wait time in excess of one hour; or o Handicap accessibility.

A member or a member's representative may file a standard grievance request either orally (via Customer Service or in person) or in writing within 60 calendar days of the date of the incident or when the member was made aware of the incident.

Grievance Resolution

Standard

A member or member's representative shall be notified of the decision as expeditiously as the case requires, based on the member's health status, but no later than 30 calendar days after the date Superior Select receives the verbal or written grievance, consistent with applicable federal law. Unless an extension is elected, Superior Select will send a closure letter upon completion of the member's grievance.

An extension of up to 14 calendar days may be requested by the member or the member's representative. Superior Select may also initiate an extension if the need for additional information can be justified and the extension is in the member's best interest. In all cases, extensions must be well-documented. Superior Select will provide the member or the member's representative prompt written notification regarding Superior Select's intention to extend the grievance decision.

The Grievance Department will inform the member of the determination of the grievance as follows:

- All grievances submitted, either verbally or in writing, will be responded to in writing; and
- All grievances related to quality of care will include a description of the member's right to file a written complaint with Quality Healthcare Management office (QHCM). For any complaint submitted to QHCM, Superior Select will cooperate with the QHCM in resolving the complaint.

Superior Select provides all members with written information about the grievance procedures/process available to them, as well as the complaint processes. Superior Select also provides written information to members and/or their appointed representative(s) about the grievance procedure at initial enrollment, upon involuntary disenrollment initiated by Superior Select, upon the denial of a member's request for an expedited review of a determination or appeal, upon the member's request, and annually thereafter. Superior Select will provide written information to members and/or their appointed representatives about the QHCM process at initial enrollment and annually thereafter.

The facts surrounding a complaint will determine whether the complaint is for coverage determination, organization determination or an appeal and will be routed appropriately for review and resolution.

Expedited

A member may request an expedited grievance if Superior Select makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. Superior Select will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review timeframe or extend a review timeframe does not jeopardize the member's health.

Superior Select will contact the member or the member's representative via telephone with the determination and will mail the resolution letter to the member or the member's representative within three business days after the determination is made. The resolution will also be documented in the member's record.

Section 8: Compliance

Compliance Program - Overview

Superior Select's corporate ethics and compliance program, as may be amended from time to time, includes information regarding Superior Select's policies and procedures related to fraud, waste and abuse, and provides guidance and oversight as to the performance of work by Superior Select, Superior Select employees, contractors (including delegated entities) and business partners in an ethical and legal manner. All providers, including provider employees and provider subcontractors and their employees, are required to comply with Superior Select compliance program requirements. Superior Select's compliance-related training requirements include, but are not limited to, the following initiatives:

- Corporate Integrity Agreement (CIA) Training o Effective April 26, 2011, Superior Select's CIA with the OIG of the United States Department of Health and Human Services (HHS) requires that Superior Select maintain and build upon its existing Compliance Program and corresponding training.
    - Under the CIA, the degree to which individuals must be trained depends on their role and function at Superior Select.
- HIPAA Privacy and Security Training
    - Summarizes privacy and security requirements in accordance with the federal standards established pursuant to HIPAA and subsequent amendments to HIPAA;
    - Training includes, but is not limited to discussion on:
- Proper uses and disclosures of PHI;
- Member rights; and
- Physical and technical safeguards.
- Fraud, Waste and Abuse (FWA) Training
    - Must include, but not limited to:
        - Laws and regulations related to fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
        - Obligations of the provider including provider employees and provider subcontractors and their employees to have appropriate policies and procedures to address fraud, waste, and abuse;
        - Process for reporting suspected fraud, waste and abuse;
        - Protections for employees and subcontractors who report suspected fraud, waste and abuse; and
        - Types of fraud, waste and abuse that can occur.

Providers, including provider employees and/or provider sub-contractors, must report to Superior Select any suspected fraud, waste or abuse, misconduct or criminal acts by Superior Select, or any provider, including provider employees and/or provider sub-contractors, or by Superior Select members. Reports may be made anonymously through the Superior Select FWA hotline at **1-844-372-1164**. Details of the corporate ethics and compliance program may be found on Superior Select's website at www.superiorselectMedicare.com.

Marketing Medicare Dual Advantage Plans

Medicare Dual Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V (replacing regulations formerly at 42 CFR 422.80), and the CMS *Managed Care Manual*, Chapter 3, *Medicare Marketing Guidelines for MA Plans, MA-PDs, PDPs and*

1876 Cost Plans (Marketing Guidelines), including without limitation materials governing "Provider Based Activities" in Section 70.8.3.

Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V and the Marketing Guidelines.

CMS holds plan sponsors such as Superior Select responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Providers are not authorized to engage in any marketing activity on behalf of Superior Select without the prior express written consent of an authorized Superior Select representative, and then only in strict accordance with such consent.

Code of Conduct and Business Ethics

Overview

Superior Select has established a Code of Conduct and Business Ethics that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Superior Select's Code of Conduct and Business Ethics policy can be found at www.superiorselectMedicare.com

The Code of Conduct and Business Ethics is the foundation Superior Select's Corporate Ethics and Compliance Program. It describes Superior Select's firm commitment to operate in accordance with the laws and regulations governing its business and accepted standards of business integrity. All associates, covered persons as defined by the CIA, participating providers and other contractors should familiarize themselves with Superior Select's Code of Conduct and Business Ethics. Superior Select associates, covered persons, participating providers and other contractors of Superior Select are encouraged to report compliance concerns and any suspected or actual misconduct using the Compliance Hotline at **844-372-1164**. Report suspicions of fraud, waste and abuse by calling Superior Select's FWA Hotline **844-372-1164.**

Fraud, Waste and Abuse

Superior Select is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. Superior Select has developed an aggressive, proactive fraud and abuse program designed to collect, analyze and evaluate data in order to identify suspected fraud and abuse. Detection tools have been developed to identify patterns of health care service use, including over-utilization, unbundling, up-coding, misuse of modifiers and other common schemes.

Federal and state regulatory agencies, law enforcement, and Superior Select vigorously investigate incidents of suspected fraud and abuse. Providers are cautioned that unbundling, fragmenting, up-coding, and other activities designed to manipulate codes contained in the *International Classification of Diseases, Ninth Edition* (ICD-9) or its successors, CPT-4, the Healthcare Common Procedure Coding System (HCPCS), and/or *Universal Billing Revenue Coding Manual* as a means of increasing reimbursement may be considered an improper billing practice and may be a misrepresentation of the services actually rendered.

In addition, providers are reminded that medical records and other documentation must be legible and support the level of care and service indicated on claims. Providers engaged in fraud and abuse may be subject to disciplinary and corrective actions, including but not limited to, warnings, monitoring, administrative

sanctions, suspension or termination as an authorized provider, loss of licensure, and/or civil and/or criminal prosecution, fines and other penalties.

Participating providers must be in compliance with all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicaid managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA training program.

Confidentiality of Member Information and Release of Records

Medical records should be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the member or her or his case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All provider practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure there is a procedure or process in place for maintaining confidentiality of members' medical records and other PHI as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every provider practice is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees who have access to member records and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to the following:

- Medical records;
- Communication between a member and a physician regarding the member's medical care and treatment;
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
- Any communication with other clinical persons involved in the member's health, medical and behavioral care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.);
- Member transfer to a facility for treatment of drug abuse, alcoholism, behavioral or psychiatric problem;
- Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

The NPP informs the patient or member of their member rights under HIPAA and how the provider and/or Superior Select may use or disclose the member's PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or member.

Section 9: Delegated Entities

Overview

Superior Select may, by written contract, delegate certain functions under Superior Select's contracts with CMS and/or applicable State governmental agencies. These functions include, but are not limited to, contracts for administration and management services, marketing, utilization management, quality assurance, care management, disease management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing and sales and adjudicating Medicare organization determinations, and appeals and grievances (the Delegated Services). Superior Select may delegate all or a portion of these activities to another entity (a Delegated Entity).

Superior Select oversees the provision of services provided by the delegated entity and/or subdelegate, and is accountable to the federal and state agencies for the performance of all delegated functions. It is the sole responsibility of Superior Select to monitor and evaluate the performance of the delegated functions to ensure compliance with regulatory requirements, contractual obligations, accreditation standards and Superior Select policies and procedures.

Compliance

Superior Select's compliance responsibilities extend to delegated entities, including, without limitation:

- Compliance Plan;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse Training;
- Cultural Competency Plan; and
- Disaster Recovery and Business Continuity.

Refer to *Section 8: Compliance* of this Manual for additional information regarding compliance requirements.

Superior Select ensures compliance through the delegation oversight process and the Delegation Oversight Committee (DOC). The DOC and its committee representatives:

- Ensure that all delegated entities are eligible for participation in the Medicaid and Medicare programs;
- Ensure that Superior Select has written agreements with each delegated entity that specifies the responsibilities of the delegated entity and Superior Select, reporting requirements, and delegated activities in a clear and understandable manner;
- Ensure that the appropriate Superior Select associates have properly evaluated the entity's ability to perform the delegated activities prior to delegation;
- Provide formal, ongoing monitoring of the entity's performance at least annually, including monitoring to ensure quality of care and quality of service is not compromised by financial incentives; and
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate.

Section 10: Dual-Eligible Members

Overview

Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit are often referred to as "dual-eligible members." These benefits are sometimes referred to as Medicare Savings Programs (MSPs). Dual-eligible members are eligible for some form of Medicaid benefit, whether that Medicaid coverage is limited to certain costs, such as Medicare premiums, or the full benefits covered under the Arkansas State Medicaid plan.

Types of Dual-Eligible Members

States administer MSPs for Medicare- and Medicaid-eligible members with limited income and resources to help pay for their Medicare cost-sharing. There are multiple MSP categories and the categories are based upon the beneficiary's income and asset levels as well as "medically needy" status. Members learn of their MSP assistance from an award letter they receive from the state Medicaid agency.

For full definitions of the current categories of dual-eligible members contained herein, see *Section 13: Definitions and Abbreviations* in this Manual.

See the chart below for the different categories of dual-eligible members:

Medicare Savings Program (MSP) Assistance	Fee-forservice Part A Premium Covered?	Fee-forservice Part B Premium Covered?	Part A and B Cost-Sharing Covered?	Full Medicaid Benefits Provided?
Qualified Medicare Beneficiary (QMB)	YES	YES	YES	NO
QMB Plus (QMB+)	YES	YES	YES	YES
Specified LowIncome Medicare Beneficiary (SLMB)	NO	YES	NO	NO
SLMB Plus (SLMB+)	NO	YES	YES	YES
Qualifying Individual (QI)	NO	YES	NO	NO
Qualified Disabled Working Individual (QDWI)	YES	NO	NO	NO
Full Benefit DualEligible Members (FBDE)	YES	YES	YES	YES

In general, QMB, QMB+, SLMB+ and FBDE beneficiaries are considered "zero cost-share" dual-eligible members since they pay no Part A or Part B cost-share. Please note, the state Medicaid agency defines all state optional MSP levels and those levels may vary among states. Please contact the state Medicaid agency for full MSP information.

Payments and Billing

For all zero cost-share dual-eligible members (QMB, QMB+, SLMB+ and FBDE), Medicaid is responsible for deductible, coinsurance, and co-payment amounts for Medicare **Parts A and B Covered Services**. The filed cost-sharing amounts related to supplemental benefits (e.g. hearing, vision and extra dental) are the responsibility of the member.

Providers may not "balance bill" these members. This means providers may not bill these members for either the balance of the Medicare rate or the provider's customary charges for Part A or B services. The member is protected from liability for Part A and B charges, even when the amounts the provider receives from Medicare and Medicaid are less than the Medicare rate or less than the provider's customary charges. Providers who bill these members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

Providers agree to accept Superior Select's payment as payment in full or will bill the appropriate state source for the cross-over cost-sharing payment. To bill the state, the provider will submit the EOP provided by Superior Select to the state.

If Superior Select has assumed the state's financial responsibility under an agreement between Superior Select and the state, Superior Select shall be considered the "appropriate state source." If Superior Select has assigned responsibility to a delegated vendor, the delegated vendor shall be considered the "appropriate state source."

Some DSNP Plans will have a Part B deductible amount applied prior to payment similar to how Medicare operates today (excluding Florida, Texas, and California). This deductible is considered a cost-sharing amount and covered by the state Medicaid agency or its designee if they have Managed Medicaid or by Superior Select via an agreement with the state. Providers should bill Superior Select as they do today and submit the EOP provided by Superior Select to the state for payment. If Superior Select is responsible for this amount via an agreement with the state, Superior Select will pay this amount on behalf of the state.

Members who enroll after January of each year might have had their deductible amount paid for previously by the State or another health plan. In this instance Providers should follow the billing process identified above and then send Best Available Evidence (BAE) illustrating that the member has met their deductible. An example of BAE could be a remittance from the state/health plan illustrating that they have met the member's deductible previously. If the BAE is submitted and approved, Superior Select will readjudicate the claim and send appropriate payment to the Provider.

Services that apply to the DSNP Part B deductible include:

- Cardiac Rehabilitation Services
- Intensive Cardiac Rehabilitation Services
- Pulmonary Rehabilitation Services
- Partial Hospitalization
- Chiropractic Services
- Occupational Therapy Services (Except in GA)
- Physician Specialist Services
- Outpatient Behavioral Health Specialty Services
- Podiatry Services

- Other Health Care Professional
- Psychiatric Services
- Physical Therapy and Speech-Language Pathology Services (Except in GA)
- Medicare Covered Outpatient Diagnostic Procedures/Tests & Lab Services
- Diagnostic Radiological Services
- Therapeutic Radiological Services
- Outpatient X-Rays
- Outpatient Hospital Services
- Ambulatory Surgical Center (ASC) Services
- Outpatient Substance Abuse
- Outpatient Blood Services
- Ambulance Services
- Durable Medical Equipment (DME)
- Prosthetics/Medical Supplies
- End-Stage Renal Disease
- Kidney Disease Education Services
- Diabetes Self-Management Training

Referral of Dual-Eligible Members

When a participating provider refers a dual-eligible member to another provider for services, the provider should make every attempt to refer the dual-eligible member to a provider who participates with both Superior Select and the state Medicaid agency. Providers who participate with the state Medicaid plan can be located at the applicable state's Medicaid website. The Superior Select Medicare Provider Directory displays an indicator when the provider participates in Medicaid.

Dual-Eligible Members Who Lose Medicaid Eligibility/Status

Many dual-eligible members are members of Dual Special Needs Plans (DSNPs). For more information on DSNPs, refer to *Section 1: Welcome to Superior Select.*

CMS requires DSNP plans to provide a member a period of at least 30 days and up to six months to allow those dual-eligible members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the "Deeming Period". A change in status occurs when a dual-eligible member either loses Medicaid eligibility or when a change in Medicaid eligibility occurs that impacts the member responsibility. As of January 1, 2012, Superior Select will implement a three month Deeming Period for all DSNP plans.

During the Deeming Period, Superior Select applies the appropriate payment methodology to process claims and pays 100% of the Medicare allowable for all plans except the Florida *Select* Plan to protect its members from cost-sharing. Providers must accept Superior Select's payment as payment in full and may not balance bill the member. During the Deeming Period, certain members in the Florida *Select* Plan may be responsible for cost sharing.

DSNP Care Management Program

Overview

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law in July of 2008. MIPPA mandates a health risk assessment, care plan, interdisciplinary care team for members, and an evaluation of care effectiveness by the health plan.

Superior Select's Model of Care (MOC) is tailored specifically to the dual-eligible members in an effort to meet the populations' functional, psychosocial and medical needs in a member-centric fashion.

Health Risk Assessment: Conducted by Superior Select – Superior Select's Care Management MOC begins with the HRA. The HRA assesses member risk in the following areas: functional, psychosocial, and medical. Once completed, the HRA is stratified and then reviewed by a care manager. The stratification/acuity of the HRA is an indicator of the needs of the member and is verified with the comprehensive medical assessment. Superior Select utilizes four levels of stratification/acuity starting with level 1 (low risk) and going to level 4 (high risk). The dualeligible member is then contacted so the Care Management process can begin.

Comprehensive Medical Assessment: Conducted by Superior Select – The care manager telephonically conducts the comprehensive medical assessment with the dual-eligible member and/or caregiver, if appropriate, in order to collect additional social, medical, and behavioral information to generate a member-centric Individualized Care Plan (ICP). The comprehensive medical assessment is based on *Clinical Practice Guidelines* and allows the care plan to be generated utilizing these guidelines.

Individualized Care Plans: Generated by Superior Select – Once the care manager, the member, and/or caregiver complete the comprehensive medical assessment, an ICP is generated that reflects the member's specific problems, prioritized goals, and interventions. The care manager and the member and/or caregiver, if appropriate, agree on the care plan and set goals. The ICP generated tracks dates and goal progress. The frequency of contact will vary depending on the stratification/acuity of the member and specific goal timeframes. The ICP is shared with all members of the Interdisciplinary Care Team (ICT) for input and updates.

Interdisciplinary Care Team: Superior Select and Providers – The care manager shares the ICP with all the members of the ICT in an effort to provide feedback and promote collaboration regarding the member's goals and current health status. At a minimum, the ICT includes the member, the member's caregiver (if appropriate), the member's PCP and Superior Select care manager. Other members of the ICT can include specialists, social service support, behavioral health specialists, and/or caregiver and others depending on the member's specific needs. The care manager communicates and coordinates with the members of the ICT to educate the member, provide advocacy, and assist them as they navigate the health care system.

Care Transitions: Superior Select and Providers – The care manager is responsible for coordinating care when members move from one setting to another and facilitates transitions through communication and coordination with the member and their usual practitioner. During this communication with the member, the care manager will discuss any changes to the member's health status and any resulting changes to the care plan. The care manager will notify the member's usual provider of the transition and will communicate any needs to assist with a smoother transition process.

Provider Required Participation

To meet the intent of the MIPPA legislation, providers are required to participate in the MOC for all DSNP plan members. The expectations for participation are as follows:

- Complete the required MOC training. Superior Select offers an online training module and a printable self-study packet. If providers opt to use the self-study packet, Superior Select requests they return the attestation via fax for reporting purposes. Both the online module and self-study packet can be accessed at **https://www.Superior Select.com/provider/training**. If providers would like to request a copy mailed, at no cost, they can contact Provider Services or their Provider Relations representative;
- Become familiar with Superior Select's *Clinical Practice Guidelines* which are based on nationally-recognized evidence-based guidelines;
- Read newsletters that feature articles regarding the latest treatments for patients;
- Review and update the member care plan faxed by the Care Management Department; and
- Participate in the ICT for all DSNP members in a provider's membership panel and give feedback as appropriate. The care manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the dual-eligible member to meet the goals of the ICP.

Re-cap of the benefits of the DSNP Care Management Program:

- All members receive a Health Risk Assessment.
- Members are stratified according to the severity of their disease process, functional ability, and psychosocial needs.
- A Comprehensive Medical Assessment is completed by the care manager and is the basis for the ICP.
- The ICP is generated by the care manager in collaboration with the member and the care team.
- The ICP is shared with the ICT for review and comments as needed.
- The care ,manager continues to monitor, educate, coordinate care and advocate on behalf of the member.

Section 11: Pharmacy

Superior Select's pharmaceutical management procedures are an integral part of the pharmacy program that promote the utilization of the most clinically appropriate agent(s) to improve the health and well-being of members. The utilization management tools that are used to optimize the pharmacy program include:

- Formulary;
- Prior Authorization;
- Step Therapy;
- Quantity Limit; and
- Mail Service.

These processes are described in detail below. In addition, prescriber and member involvement is critical to the success of the pharmacy program. To help patients get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., National Institutes of Health (NIH) Asthma guideline, Joint National Committee (JNC) VIII Hypertension guidelines;
- Prescribe drugs listed on the formulary;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

For more information on Superior Select's pharmacy benefits, visit Superior Select's website at **www.superiorselectMedicare.com**.

Formulary

The formulary is a published prescribing reference and clinical guide of prescription drug products selected by the Pharmacy and Therapeutics (P&T) Committee. The formulary denotes any of the pharmacy utilization management tools that apply to a particular pharmaceutical.

The P&T Committee's selection of drugs is based on the drug's efficacy, safety, side effects, pharmacokinetics, clinical literature, and cost-effectiveness profile. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization and step therapy).

The formulary is located on Superior Select's website at **www.superiorselectMedicare.com**

Any changes to the list of pharmaceuticals and applicable pharmaceutical management procedures are communicated to providers via the following:

- Quarterly updates in provider and member newsletters;
- Website updates; and/or
- Pharmacy and provider communication that detail any major changes to a particular therapy or therapeutic class.

Additions and Exceptions to the Formulary

To request consideration for inclusion of a drug to Superior Select's formulary, providers may write Superior Select, explaining the medical justification.

For more information on requesting exceptions, refer to the *Coverage Determination* process below.

Coverage Limitations

The following is a list of non-covered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a noncosmetic purpose (i.e., morbid obesity));
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Agents when used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Nonprescription over-the-counter (OTC) drugs;
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and
- Agents when used for the treatment of sexual or erectile dysfunction. Erective dysfunction drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension).

Generic Medications
Superior Select covers both brand name drugs and generic drugs. A generic drug is approved by the (FDA) as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Step Therapy
Step Therapy programs are developed by the P&T Committee. These programs encourage the use of therapeutically equivalent, lower-cost medication alternatives (first-line therapy) before "stepping up" to less cost-effective alternatives. Step therapy programs are intended to be a safe and effective method of reducing the cost of treatment by ensuring that an adequate trial of a proven safe and cost-effective therapy is attempted before progressing to a more costly option. First-line drugs are recognized as safe, effective and economically sound treatments. The first-line drugs on Superior Select's formulary have been evaluated through the use of clinical literature and are approved by Superior Select's P&T Committee.

Medicare Part D drugs requiring step therapy are designated by the letters "ST" on Superior Select's formulary.

Prior Authorization
Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior authorization protocols indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s)).

Part D drugs requiring prior authorization are designated by the letters "PA" on Superior Select's formulary.

Quantity Limits
Quantity limits are used to encourage that pharmaceuticals are supplied in a quantity consistent with FDA-approved dosing guidelines. Quantity limits are used to help prevent billing errors.

Part D drugs that have quantity limits are designated by the letters "QL", and the quantity permitted, on Superior Select's formulary.

Therapeutic Interchange
Therapeutic interchange is not a Formulary Benefit Management tool which Superior Select utilizes.

Injectable and Infusion Services
Self-injectable medications, specialty medications, and home infusion medications are covered as part of the outpatient pharmacy benefit. Non-formulary injectable medications and those listed on the formulary with a prior authorization will require submission of a request form for review. For more information, refer to the *Obtaining a Coverage Determination Request* section below.

Over-the-Counter Medications
Medications available to the member without a prescription are not eligible for coverage under the member's Medicare Part D benefit.

Member Co- Payments

The co-payment and/or coinsurance are based on the drug's formulary status, including tier location, and the member's subsidy level. Refer to the member's Summary of Benefits for the exact co-pay/coinsurance located on Superior Select's website at **www.superiorselectMedicare.com**.

Coverage Determination Request Process

The goal of the Coverage Determination Request program is to ensure that medication regimens that are high-risk, have a high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

The Coverage Determination request process is required for:

- Drugs not listed on the formulary;
- Drugs listed on the formulary with a prior authorization;
- Duplication of therapy;
- Prescriptions that exceed the FDA daily or monthly quantity limits or prescriptions exceeding the permitted noted on the formulary;
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office; and
- Drugs that have a step edit and the first line therapy is inappropriate.

Obtaining a Coverage Determination Request

Complete a *Coverage Determination Request Form* and fax it to the Pharmacy Department. The form is on Superior Select's website at **www.superiorselectMedicare.com**.

Superior Select's standard is to respond to Coverage Determination requests within 72 hours for routine requests and 24 hours for expedited requests from the time when Superior Select receives the request.

The provider must provide medical history and/or other pertinent information when submitting a *Coverage Determination Request Form* for medical exception.

If the Coverage Determination Request meets the approved P&T Committee's protocols and guidelines, the provider and/or pharmacy will be contacted with the Coverage Determination request approval. An approval letter is also sent to the member and a telephonic attempt is made to inform them of the approval.

If the Coverage Determination Request is not a candidate for approval based on approved P&T Committee protocols and guidelines, it is initially reviewed by a clinical pharmacist and secondly reviewed by a Superior Select Medical Director for final determination.

For those requests that are not approved, a follow-up *Drug Utilization Review (DUR)* Form is faxed to the provider stating why the Coverage Determination Request was not approved, including a list of the preferred drugs that are available as alternatives, if applicable. A denial letter is also sent to the member and a telephonic attempt is made to inform them of the denial.

Medication Appeals

To request an appeal of a Coverage Determination Request decision, contact the Pharmacy Appeals Department via fax, mail, in person or phone. Refer to Superior Select's website at **www.superiorselectMedicare.com** for more information.

Once the appeal of the Coverage Determination Request decision has been properly submitted and obtained by Superior Select, the request will follow the appeals process described in *Section 7: Reconsiderations (Appeals) and Grievances*.

Section 13: Definitions and Abbreviations

Definitions

The following terms as used in this Provider Manual shall be construed and/or interpreted as follows, unless otherwise defined in the participation Agreement providers have with Superior Select.

"**Appeal"** means a request for review of some action taken by or on behalf of Superior Select.

"**Benefit Plan"** means a health benefit policy or other health benefit contract or coverage document (a) issued by Superior Select or (b) administered by Superior Select pursuant to a government contract. Benefit plans and their designs are subject to change periodically.

"Centers for Medicare and Medicaid Services (CMS)" means the United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

"**Clean Claim"** means a claim for Covered Services provided to a member that (a) is received timely by Superior Select, (b) has no defect, impropriety, or lack of substantiating documentation from the member's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional Superior Select-specific requirements in the *Superior Select Companion Guide*, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Superior Select to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to members, and (2) determine payor liability, and ensure timely processing and payment by Superior Select. A clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

"Co-Surgeon" means one of multiple surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure.

"Covered Services" means medically necessary health care items and services covered under a benefit plan.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.

"Encounter Data" means encounter information, data and reports for Covered Services provided to a member that meets the requirements for clean claims.

"FBDE" means full benefit dual-eligible members who are eligible to have full Medicaid benefits (SLMB+ and QMB+).

“Formulary” means a list of covered drugs selected by Superior Select in consultation with a team of health care providers on the Pharmacy and Therapeutics (P&T) Committee, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

“Grievance” means any complaint or dispute, other than one that involves a Superior Select determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Superior Select, regardless of whether remedial action can be taken. Grievances may include, but are not limited to, complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

“Ineligible Person” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority for Federal Health Care Programs described in Section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State Governmental Authority.

“**Medically Necessary**” or “**Medical Necessity**” means those health care items or services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member’s needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the member, the member’s caretaker or the health care provider, and (vi) not custodial care as defined by CMS. For health care items and services provided in a hospital on an inpatient basis, “medically necessary” also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a health care provider has prescribed, recommended or approved health care items or services does not, in itself, make such items or services medically necessary.

“Member” means an individual properly enrolled in a benefit plan and eligible to receive Covered Services at the time such services are rendered.

“Member Expenses” means copayments, coinsurance, deductibles or other cost share amounts, if any, that a member is required to pay for Covered Services under a benefit plan. **“Members with Special Health Care Needs”** means adults and children who face daily physical, behavioral or environmental challenges that place their health at risk and whose ability to fully function in society is limited.

“PCP” means a primary care provider.

“Provider” means an individual or entity that has contracted, directly or indirectly, with Health Plan to provide or arrange for the provision of Covered Services to members under a benefit plan.

“Reopening” means a remedial action taken to reconsider a final determination or decision even though the determination or decision was correct based on the evidence of record.

Abbreviations

ACS - American College of Surgeons

AEP – annual enrollment period

Agreement – Provider Participation Agreement

AHP – allied health professional

AIDS - Acquired Immune Deficiency Syndrome

ALJ – administrative law judge

AMA – American Medical Association

ARNP – Advanced Registered Nurse Practitioner

CAD – coronary artery disease

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CDSC – Controlled Dangerous Substance

CHF – congestive heart failure

CIA – Corporate Integrity Agreement

CLAS – culturally and linguistically appropriate services

CMS – Centers for Medicare and Medicaid Services

CNM – Certified Nurse Midwife

COB – coordination of benefits

COPD – chronic obstructive pulmonary disease

CORF – comprehensive outpatient rehabilitation facility

CPT-4 – *Physician’s Current Procedural Terminology, 4th Edition*

CSR – Controlled Substance Registration

DDE – direct data entry

DEA – Drug Enforcement Agency

DM – Disease Management

DME – durable medical equipment

DOC – Delegation Oversight Committee

DSM-IV - *Diagnostic and Statistical Manual of Mental Disorders*

DSNP – Dual-Eligible Special Needs Plans

EDI – electronic data interchange

EOB – Explanation of Benefits

EOP – Explanation of Payment

ESRD – end-stage renal disease

FBDE – Full Benefit Dual-Eligible Members

FDA – Food and Drug Administration

FFS – fee-for-service

FWA – fraud, waste, and abuse

HEDIS® - Healthcare Effectiveness Data and Information Set

HHA – home health agency

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIV – Human Immunodeficiency Virus

HMO – health maintenance organization

HMO-POS – health maintenance organization with point of service option

HOS – Medicare Health Outcomes Survey

HRA – Health Risk Assessment

HTN – hypertension

ICD-9 - *International Classification of Diseases, Ninth Edition*

ICP – Individualized Care Plans

ICT – Interdisciplinary Care Team

INR – inpatient nursing rehabilitation facility

IPA – independent physician association

IRE – Independent Review Entity

IVR – interactive voice response

JNC – Joint National Committee

LCSW – Licensed Clinical Social Worker

LTAC – long term acute care facility

MA – Medicare Advantage

MAC – Medicare Appeals Council

MIPPA – Medicare Improvements for Patients and Providers Act of 2008 MOC – Model of Care

MOOP – maximum out of pocket

MSP – Medicare Savings Programs

NCCI – National Correct Coding Initiative

NCQA – National Committee for Quality Assurance

NDC – National Drug Codes
NIH – National Institutes of Health
NPI – National Provider Identifier
NPP – Notice of Privacy Practice
OA – Osteopathic Assistant
OB – obstetric / obstetrical / obstetrician OIG –
Office of Inspector General OT – occupational
therapy
OTC – over-the-counter
P&T – Pharmacy and Therapeutics Committee
PA – Physician Assistant
PCP – primary care provider
PHI – protected health information
POS – point of service
PPC – provider-preventable condition
Provider ID – provider identification number
PT- physical therapy
QDWI – Qualified Disabled Working Individual
QI – Qualifying Individual
QI Program – Quality Improvement Program
QHCM – Quality Improvement Organization
QMB – Qualified Medicare Beneficiary
QMB+ - Qualified Medicare Beneficiary Plus
RN – Registered Nurse
SFTP – secure file transfer protocol
SIE – site inspection evaluation
SLMB – Specified Low-Income Medicare Beneficiary
SLMB+ - Specified Low-Income Medicare Beneficiary Plus
SNF – skilled nursing facility
SNIP – Strategic National Implementation Process
SSN – Social Security Number
ST – speech therapy
Tax ID / TIN – tax identification number
TNA – Transition Needs Assessment

TOC – transition of care

UM – utilization management

WEDI - Workgroup for Electronic Data Interchange

Section 14: Superior Select Resources

Superior Select Homepage https://www.SuperiorSelectMedicare.com

Provider Homepage https://www.SuperiorSelectMedicare.com/provider