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1.1 MISSION STATEMENT

Mission

We distinguish ourselves through service excellence and by providing value through affordable insurance solutions and access to high quality, cost-effective medical care.

Vision

We will be the health plan of choice in our service area, known for our nationally recognized quality and service and our affordable insurance products.

1.2 SENIOR PREFERRED HMO PRODUCT

Senior Preferred HMO is a Medicare Advantage Health Maintenance Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to provide benefits to members. This program is designed to provide quality, affordable care to Medicare eligible recipients.

Senior Preferred HMO is attractive to Medicare beneficiaries for many reasons, including –

- Quality care
- An affordable price
- Comprehensive provider network
- Ease-of-use
- Member’s ability to budget health care costs
- Additional benefits covered

This plan allows Medicare eligible members an alternative to the traditional Fee-For-Service Medicare program. Senior Preferred is an HMO with a Medicare contract.

1.3 USING THE PROVIDER MANUAL

Purpose

The Senior Preferred HMO Provider Manual is designed specifically for Senior Preferred HMO providers. This Provider Manual provides specific information needed for the care and treatment of Senior Preferred HMO members. This Provider Manual defines policies, procedures and guidelines required by CMS, external accreditation agencies, as well as Senior Preferred.

Updates or Revisions

The Senior Preferred HMO Provider Manual is updated on a routine basis. The most current version is available online at SeniorPreferred.org/for-providers.

The use of the term “Provider” in this document

We acknowledge that the National Committee for Quality Assurance (NCQA) differentiates between a practitioner (person) and a provider (facility). However, to simplify the text within this document, we have decided to use the term “provider” as an all-encompassing term that includes facilities as well as physicians, practitioners, and any other staff who are directly or indirectly contracted to provide service to our members.

1.4 PROVIDER RESPONSIBILITIES - SENIOR PREFERRED’S EXPECTATIONS OF PROVIDERS

Senior Preferred HMO expects contracted providers to–

- Understand that Senior Preferred HMO does not deny patient care, but simply makes payment decisions based on the member’s coverage;
- Act in the best interest of the members;
- Address a diverse patient population in a culturally competent manner;
- Communicate fully with members regarding their illness, as well as diagnostic treatment options, medication treatments and therapeutic options available to them regardless of benefit coverage;
- Allow members to participate in their health care decisions;
- Effectively address and overcome any barriers with respect to Member’s compliance with prescribed treatments and regimes;
- Provide continuity of care for members by ensuring that there is an appropriate confidential exchange of medical information between all providers involved;
- Refer members for specialty care or second opinions within the Senior Preferred HMO provider network, and obtain written approval from Medical Management when care is necessary outside of the Senior Preferred HMO network;
- Practitioners / providers are required to assist Senior Preferred HMO members in obtaining Prior Authorization, as necessary, to facilitate claim payment. Services requiring Prior Authorization are listed in Appendix Section 12.7 of this Provider Manual;

- Participate in Senior Preferred's utilization management and quality improvement initiatives, including allowing Senior Preferred HMO reasonable access to member medical records at no cost;
- Recognize that there are multiple, well-accepted means of diagnosis and treatment for many given conditions;
- Inform the Medical Director when the Senior Preferred HMO procedures or actions are perceived as threatening the health or well-being of the member;
- Communicate with members and Senior Preferred HMO in a way that assumes that all parties are acting in good faith with the goal being good care for the member;
- Recognize that Senior Preferred HMO is obligated to develop policies and procedures on benefit administration and to administer these in a fair and consistent manner even though this occasionally results in denial of payment for individual members;
- Understand that Senior Preferred's goal is to improve access and quality of health care; and
- Complete a successful credentialing program prior to contact with Senior Preferred HMO members.

1.5 SENIOR PREFERRED HMO RESPONSIBILITIES

Participating Providers can expect Senior Preferred HMO to –

- Assist the provider in meeting the expectations of Senior Preferred HMO participation;
- Pay claims fairly and efficiently;
- Provide due process to the provider when complaints or grievances are lodged against him or her;
- Support the provider in practice by identifying opportunities to improve care when information is available on a practice basis or an individual member basis;
- Maintain an appeals process that can respond quickly and appropriately to members and providers;
- Educate and encourage members to be seen for appropriate preventive services;
- Inform providers of quality or other initiatives that may affect them or the members; and
- Work in all our operational areas to improve service to providers and members.

1.6 SENIOR PREFERRED HMO SERVICE AREA

The Provider Network

Senior Preferred HMO has a comprehensive network that includes clinics, hospitals, skilled nursing facilities, home health, chiropractic and other health care professionals.

Senior Preferred HMO ensures the integrity of the network through quality initiatives such as credentialing, utilization review and ongoing quality programs.

The counties in our service area are listed below.

Wisconsin

- Buffalo, Columbia, Crawford, Dane, Iowa, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Trempealeau, Vernon and Waukesha.

Minnesota

- Fillmore, Houston, Winona

Iowa

- Allamakee, Clayton, Fayette, Howard and Winneshiek

Illinois

- Winnebago

Senior Preferred HMO Provider Directory

The most up-to-date listing of participating providers is located on the Provider page of Senior Preferred's website at SeniorPreferred.org/for-providers. Contact the Provider Relations department at (800) 394-5566 with any questions.

SECTION 2: STAFF AND SERVICES

2.1 Hours, Location, Mailing and Internet Addresses

2.2 Senior Preferred HMO Telephone Directory

2.3 Sales

2.1 HOURS, LOCATION, MAILING AND INTERNET ADDRESSES

Hours of Operation

Senior Preferred HMO is available by phone Monday through Friday, 8 a.m. to 8 p.m. A complete Senior Preferred HMO telephone directory is on the following page for your reference regarding specific functions and the areas that are responsible for these functions.

Senior Preferred's Physical Location

Senior Preferred HMO is located in the Quartz Seven Rivers building, 2651 Midwest Drive, Onalaska, WI 54650.

You can meet with a Customer Service representative Monday through Friday, from 8 a.m. - 4:30 p.m. at the Quartz Seven Rivers building located at 2651 Midwest Drive, Onalaska, Wisconsin. In addition, you can meet with a Customer Service representative Monday through Friday from 8 a.m. - 4:30 p.m. at the Health Resource Center located in the main lobby of the Gundersen Health System at 1836 South Avenue in La Crosse, Wisconsin.

Mailing Address

Written inquiries should be sent to –
Senior Preferred
P.O. Box 610
Sauk City, WI 53583

Internet Address

Please visit the Senior Preferred website for additional information at SeniorPreferred.org

2.2 SENIOR PREFERRED HMO TELEPHONE DIRECTORY

Contact and Service Function	<i>Telephone Numbers</i>
<p>Senior Preferred HMO Representative (Customer Service and Claims) Verify member eligibility Provide Senior Preferred HMO policies and procedures Provide member schedule of benefits Provide general information or assistance Member address or name changes Provide benefit information Record member complaints Verify member's Primary Care Physician assignment Coordination of benefits questions Determine claim status Adjustment procedure and inquiry Check for copayments Member / Provider appeals</p>	<p>(800) 394-5566</p>
<p>Configuration Questions regarding explanation of payments Questions regarding electronic claim submissions</p>	<p>(800) 394-5566</p>
<p>Provider Relations Network application and credentialing status Provide administrative support to plan requirements Contractual issues / fee schedule Provide education and training assistance Clarify Primary Care Physician administration Initiate changes in Primary Care Physician designation</p>	<p>Contact your Provider Coordinator</p>
<p>Medical Management Admission review / discharge planning Care Management Home Health / IV therapy Referrals for out-of-plan services Skilled Nursing Facilities Procedures / services requiring Prior Authorization Hospice</p>	<p>(800) 394-5566</p>

2.2 SENIOR PREFERRED HMO TELEPHONE DIRECTORY (CONT.)

Contact and Service Function	Telephone Numbers
Referrals and Authorizations Referrals for out-of-plan services Durable medical equipment Home health / IV therapy Skilled Nursing Facilities Surgical procedures Hospice	(800) 394-5566
Quality Management and Population Health Quality Review Monitoring, evaluation, improvement in the delivery of services	(800) 394-5566
Compliance Monitors compliance of Senior Preferred Provides information on state and federal laws affecting HMOs Monitors pending legislation affecting HMOs Address privacy and confidentiality issues and concerns Privacy Officer / Compliance Officer	(800) 394-5566, ext. 308151

2.3 SALES

Senior Preferred HMO has assembled a dedicated sales team who are specifically trained and licensed for sales activities. Senior Preferred HMO encourages providers to address their sales questions to the Senior Preferred Sales Team at (866) 491-1335.

Sales Restrictions

Due to the complexity of the regulations, Senior Preferred does not allow providers to act in a manner where they might be viewed as sales agents for Senior Preferred HMO. Reasons why providers should not act as sales are listed below –

1. Senior Preferred retains all authority for marketing and sales.
2. All materials that are shared with a member, including newspaper or other articles that reference Senior Preferred require prior approval by Office of the Commissioner of Insurance (OCI) and CMS.
3. If sales at sites were allowed –
 - Members may be confused whether the physician is acting in the role of a provider or as an agent of Senior Preferred.
 - Provider’s knowledge of their patient’s health status may increase the potential for both their discriminating in favor of beneficiaries with positive health status, as well as steering unhealthy patients to the higher benefit level offered by Senior Preferred.

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- Providers may not be aware of membership plan benefits or costs, or other membership information. Senior Preferred and / or the provider may bear responsibility if a benefit or cost is misrepresented.
- 4. Providers may not be the best source of membership information for their patients.
- 5. Sales activities for Senior Preferred are strictly regulated by CMS. Discussion of certain topics, including presentation or discussion of premiums or benefits, may require state licensure as an insurance agent.
- 6. Providers can distribute materials for several plans.

New Senior Preferred providers may use general advertising (e.g., radio, television) within the first 30 days of the new contract agreement. An announcement to members of a new contract which names only Senior Preferred can occur only once when such announcement is conveyed through direct mail, email or phone. Additional direct mail and / or email communication from providers to their members regarding affiliations must include all plans with which the provider contracts.

Provider websites may provide the CMS Online Enrollment Center link at <http://www.medicare.gov/find-a-plan/questions/enroll-now.aspx> to direct potential members to plan enrollment applications and / or provide downloadable enrollment applications.

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 - 3.7b Process for Submitting ESRD Annotation to CMS
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- 6.9 Emergency Room
- 3.10 Advance Directives
- 3.11 Member Rights and Responsibilities

3.1 INTRODUCTION TO SENIOR PREFERRED HMO CUSTOMER SERVICE REPRESENTATIVES

Senior Preferred Customer Service representatives are available by phone Monday through Friday, 8 a.m. - 8 p.m. to assist Senior Preferred members with any questions or concerns. From October 1 through March 31, Customer Service is also available Saturdays and Sundays from 8 a.m. -8 p.m. The Senior Preferred Customer Service representative conducts new member welcome calls and orientation sessions. **Providers with members who have questions regarding benefits, should instruct the them to call Senior Preferred Customer Service with any questions.**

As a provider, you may not always be aware of your patient's individual plan benefits or the costs involved. Senior Preferred and / or you, the provider, may have to bear the financial responsibility if a benefit or cost is misrepresented. For this reason, providers should refrain from quoting member benefits. However, providers may call the Senior

Preferred representative to verify member eligibility and inquire about member benefits.

Senior Preferred Customer Service representatives can be reached at (800) 394-5566 or TTY 711.

3.2 ELIGIBILITY AND ENROLLMENT

Eligibility, Enrollment and Effective Date

3.2a Eligibility and Enrollment

Individuals may enroll in Senior Preferred if they are entitled to Medicare Part A, enrolled under Medicare Part B, and reside in the Senior Preferred service area a minimum of six months out of the year. Eligible individuals may enroll only during specific election periods, as specified by CMS. Senior Preferred service area is defined in Section 1.6.

3.2b Effective Date

Senior Preferred will notify the member in writing of his / her effective date of coverage.

If an application for membership is rejected by CMS or Senior Preferred, the member will be notified in writing explaining the reason for rejection.

3.3 DISENROLLMENT / TERMINATION OF COVERAGE

3.3a Disenrollment

A member may discontinue coverage from Senior Preferred only during specific election periods, as specified by CMS. Disenrollment requests must be submitted in writing or may be received directly from CMS. The member must continue to receive all services from Senior Preferred participating providers / practitioners until the disenrollment date.

3.3b Coverage Termination

Senior Preferred **must** terminate a member's coverage; under the following circumstances –

- A change in residence (including incarceration) makes the individual ineligible to remain enrolled in the plan.
- The member loses entitlement to either Medicare Part A or Part B.
- The member dies.
- The Medicare Advantage (MA) organization contract is terminated or the MA organization reduces its service area to exclude the member.

- The member fails to pay his / her Part D – IRMAA to the government and CMS notifies the plan to effectuate the disenrollment.

Senior Preferred **may** terminate a member's coverage under the following circumstances –

- Premiums are not paid on a timely basis.
- The member engages in disruptive behavior.
- The member provides fraudulent information on an election form or if the member permits abuse of an enrollment card in our plan.

Should coverage be terminated for any of the reasons above, a member will receive advanced notice from Senior Preferred. Members have recourse through the Senior Preferred grievance program and / or CMS if they are terminated and disagree with the Senior Preferred position.

3.4 PRACTITIONER / PROVIDER RESPONSIBILITIES FOR VERIFICATION OF PAYER

- The practitioner / provider shall request the member's ID card before services are provided, and verify that all demographic and insurance information is correct in order to assure correct registration, billing and reporting processes.
- The practitioner, provider or designee shall contact a Senior Preferred Customer Service representative at (800) 394-5566 anytime verification of eligibility or verification of Primary Care Physician designation is necessary.
- The practitioner's office shall contact a Senior Preferred Customer Service representative at (800) 394-5566 anytime the practitioner or designee becomes aware of incorrect member information.

3.5 SENIOR PREFERRED HMO MEMBER IDENTIFICATION CARD

Upon receipt of CMS approval, a member will receive his / her Senior Preferred identification card, which he / she must use instead of their traditional Medicare card when obtaining medical services and receiving prescriptions when applicable.

3.6 SENIOR PREFERRED HMO MEMBER GRIEVANCE AND APPEAL PROCESS

Part C Grievances

Senior Preferred members have grievance rights available to them as specified in this section. A grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of Senior Preferred or its provider's operations, activities, or behavior, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part C plan refused to expedite a coverage determination or redetermination. Other examples include, but not limited to complaints regarding –

- Timeliness
- Appropriateness
- Access to, and / or setting of a provided health service
- Covered health service procedure or item during a course of treatment did not meet accepted standards of delivery of health care
- Involuntary disenrollment issues
- Physician demeanor or behavior
- Quality of service issues

Part D Grievances

A grievance means any complaint or dispute, other than one that involves a coverage determination or an LIS or LEP determination, expressing dissatisfaction with any aspects of the operations, activities or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D plan refused to expedite a coverage determination or redetermination.

Grievances may include complaints regarding the –

- Timeliness
- Appropriateness
- **Access to, and / or setting of a provided item**

Appeals

Members are entitled to a reconsideration of a denied claim or service. If the reconsideration outcome does not meet the member's desired result(s) in whole or part, the matter is turned over to MAXIMUS Federal Services, a Medicare contracted independent appeal review firm. Part C plan adverse reconsiderations will be auto-forwarded by Senior Preferred to MAXIMUS Federal Services. Part D plan adverse redeterminations will be reviewed by MAXIMUS Federal Services per member request.

Important Note: If a Senior Preferred member, gives any indication of finding the provider's assessment unsatisfactory or unacceptable, they can call a Senior Preferred Appeals Specialist at (800) 394-5566 or (608) 881-8284 as soon as possible, preferably

that same day, to advise of the potential appealable issue. If Senior Preferred issues a Notice of Denial of Coverage letter to the member, it will include the appropriate appeal rights as defined by CMS. CMS considers this letter (or corresponding claims denial) an “organizational determination.”

Please remember that an indication of “no-need” or any other direct or indirect denial of need for a requested medical service, implied or stated, constitutes an “organizational determination” regarding Senior Preferred’s coverage to members, subject to appeal rights. Senior Preferred urges practitioners / providers to call an Appeals Specialist for any questions regarding clarity or other concerns for requested medical services that you or the member / patient may have.

Please reference the following grids for an overview of the Grievance and Appeals Process and a sample of Member Rights-Grievance and Appeals information. These grids explain the differences between a complaint, grievance or an appeal, and outline the responsibilities of the provider, member and Senior Preferred.

Grievance and Appeals

Definitions of what constitute a grievance and appeal can be referenced in this Grievance and Appeals appendix.

Responsibilities of Appealing Party*	Provider Responsibilities	Senior Preferred HMO Responsibilities
<p>*A member, provider or appointed or authorized representative may appeal.</p> <ul style="list-style-type: none"> ▪ Know member rights and responsibilities. ▪ File appeal within 60 calendar days of the adverse benefit determination. ▪ Submit standard appeal requests in “writing” or “orally” to a Senior Preferred Appeals Specialist. ▪ Submit expedited appeal requests in “writing” or “orally” to a Senior Preferred Appeals Specialist. 	<ul style="list-style-type: none"> ▪ Notify members of their appeal rights when request for services are denied. (Sample of member rights can be found in the appendix labeled Grievance and Appeals.) ▪ Support member appeals, if appropriate. ▪ Provide medical record information for “time sensitive” appeal requests when applicable (i.e., expedited appeal requests, required within 24 hours). 	<p>Process expedited and standard appeals / grievances within the CMS required time frames.</p> <ul style="list-style-type: none"> ▪ Submit upheld Part C appeal denials to Maximus Federal Services (MFS). ▪ Effectuate all MFS decisions within required time frame. ▪ Pay or provide for service if decisions are overturned, and notify member within required time frame.

For questions or concerns regarding this process, please call a Senior Preferred Appeals Specialist at (800) 394-5566.

3.7 END STAGE RENAL DISEASE CARE COORDINATION

3.7a End Stage Renal Disease Definition

End stage renal disease (ESRD) is defined as a stage of kidney impairment that appears irreversible, permanent, and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare member will be assigned ESRD status by the Medicare ESRD system as a result of their provider certifying the ESRD status of the member and completing a CMS form (CMS 2728-U3). An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility.

3.7b Process for Submitting ESRD Annotation to CMS

The following items identify the process for submitting ESRD annotation to CMS.

- Physician completes CMS Form 2728-U3, Chronic Renal Disease Medical Evidence Report.
- The completed CMS Form 2728-U3 is sent to the appropriate ESRD network office by the renal provider/practitioner.
- The ESRD network offices are listed in the ESRD Program Instruction Manual that is given to each renal provider by CMS.
- The ESRD network verifies the data on CMS Form 2728-U3 and forwards the form to the ESRD support section at CMS.
- If the member is already entitled to Medicare due to age, CMS annotates the ESRD database.
- If the member is waiting for entitlement to Medicare due to ESRD, CMS does not annotate the database until Social Security Administration informs CMS of entitlement.

3.8 HOSPICE CARE COORDINATION

Coverage for hospice care for Senior Preferred members will be provided in accordance with Medicare's guidelines.

A member is eligible for hospice care only after their attending physician and the hospice medical director concur that the member is terminally ill and has a life expectancy of six months or less. Members who are appropriate for hospice care and support services will be referred to a Medicare certified hospice program for hospice care.

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Coverage Guidelines

All other services not related to the terminal illness will be considered for coverage if the member remains enrolled in Senior Preferred.

A member has the right to discontinue hospice care at any time and has the right to change hospice programs one time per benefit period.

3.9 EMERGENCY SERVICES

Emergency Services Definition

Services related to a medical condition involving acute symptoms that would lead a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention would result in serious jeopardy to the person's health, impairment to bodily functions, or serious dysfunction to one or more organs.

Emergent or Urgently Needed Care Outside the Service Area

If the member is hospitalized at a facility outside the Senior Preferred service area, the member is asked to notify Senior Preferred and / or their Primary Care Physician. Senior Preferred encourages the member's Primary Care Physician to be involved in the management of the member's care, which may include arrangements for a transfer to a participating facility once the member is stable and the condition warrants extended hospitalization.

3.10 ADVANCE DIRECTIVES

Overview

As capable adults, patients have the right to accept or refuse medical treatment, including life-sustaining treatment. In addition, a member may appoint someone else to make health care decisions on their behalf should they become mentally or physically unable to do so. To comply with these rights, Senior Preferred provides education to staff about its policy and procedure for advanced directives. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, which explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known. They can also designate a Health Care Agent who will make health care decisions on their behalf when it is determined that they are no longer capable of making these decisions for themselves.

Two types of advance directives that are commonly used

1. Living Will
2. Power of Attorney for Health Care

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As applicable, facility shall prominently document in each Senior Preferred Member's medical record whether he / she has executed an advance directive and complied with any Medicare and state law requirements regarding advance directives. Senior Preferred providers cannot refuse care or otherwise discriminate against a member based on whether the member has executed an advance directive.

Living Will

A living will is a written statement by the member. It conveys his / her choices regarding the type of life-sustaining care they would want if they had a life-threatening condition and were no longer able to communicate their wishes.

Power of Attorney for Health Care

The Power of Attorney for Health Care form allows a member to appoint another person or persons to make health care decisions on their behalf should they become unable to make these decisions for themselves. The person (or persons) appointed is called their Health Care Agent. This form does not give the health care agent any authority to make financial or other business decisions on behalf of the member.

If a member has an advance directive, they are encouraged to provide copies to their health care providers, family and their health care agent, if they have designated one.

For more information about advance directives or advance care planning, visit gundersenhealth.org/advance-care.

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3.11 MEMBER RIGHTS AND RESPONSIBILITIES

Senior Preferred's Member Rights and Responsibilities Statement shows our commitment to a mutually respectful relationship with our members and practitioners. This policy assures members that we respect their rights and communicates our expectations of the members' responsibilities as follows –

Member Rights

To choose. Members have the right to choose a Primary Care Physician from the PCPs who participate in their plan's provider network.

To obtain information. Members have the right to receive information about their rights and responsibilities as a member of Senior Preferred. Members have the right to make recommendations regarding Senior Preferred's Member Rights and Responsibilities Statement. Members have the right to obtain information about Senior Preferred and information relating to covered and excluded health plan benefits. Members also have the right to obtain information on available primary and specialty care practitioners and providers. Members have the right to receive preventive care information and information about their illness and treatment options. Members have the right to obtain information about how to file a complaint, appeal or grievance.

To have privacy and confidentiality. Members have the right to privacy and confidentiality in communications and records about their care.

To participate in their care. Members have the right to be active in decisions about their treatments. Members have the right to have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Members have the right to obtain information about the risks and benefits of treatment. Members also have the right to refuse care.

To present a complaint, appeal or grievance. Members have the right to voice concerns and to receive a prompt and fair review of their concerns.

To be treated with respect and dignity. Members have the right to be treated with respect and dignity regardless of their race, age, gender, sexual orientation or creed.

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Member Responsibilities

To choose a Primary Care Physician (PCP). Members have a responsibility to choose a PCP from the PCPs who participate in their plan's provider network and to establish a relationship with that physician.

To know their benefits and requirements. Members have a responsibility to understand their health plan benefits and limitations and to follow required procedures. Members also have a responsibility to know how to use their plan's provider network and to ask questions about things they do not understand

To provide accurate information. Members have a responsibility to provide accurate and complete information about their health history, their eligibility and their enrollment. Members have a responsibility to show their member ID card each time they receive services and to pay any out-of-pocket expenses they incur.

To participate in their care. Members have a responsibility to participate in their care by asking questions about their health. Members also have a responsibility to follow the recommended and agreed upon treatment plan for their illness and to make healthy lifestyle choices to maintain their health or manage their illness.

To keep their appointments. Members have a responsibility to keep their appointments or to give early notice if they must cancel.

To show consideration and respect. Members have a responsibility to show consideration and respect to health plan staff and health care providers.

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SECTION 4: BENEFIT INFORMATION

- 4.1 Benefit Information
- 4.2 Coordination of Benefits
- 4.3 Subrogation
- 4.4 Workers Compensation
- 4.5 Non-Coverage Specifics
- 4.6 Pre-Service Denials

4.1 BENEFIT INFORMATION

Senior Preferred administers different plan options for Senior Preferred, all with variations in benefits. Members of our Senior Preferred plans must receive primary care from a participating provider, except for urgent and emergency situations. Please contact Customer Service with questions concerning benefits available for each plan.

Customer Services representatives can be reached Monday through Friday, 8 a.m. - 8 p.m. at (800) 394-5566 or TTY 711 or (800) 877-8973.

4.2 COORDINATION OF BENEFITS

Definition

A coordination of benefits provision is an insurance contract provision intended to avoid claim payment delays and duplication of benefits when a person is covered by two or more insurance plans.

There is no coordination of benefits on a beneficiary-specific basis that would relieve a Senior Preferred member with employer / union group health plan coverage of his or her cost-sharing obligation under the Senior Preferred plan. As a result, the member remains liable for payment of the Senior Preferred plan's cost-sharing regardless of whether Senior Preferred is primary or secondary.

Coordination of Benefit Rules: Who Pays First?

- If the member is age 65 or older and has coverage under an employer group health plan with 20 or more employees, either through his / her current employment or the employment of a spouse, that coverage pays before Senior Preferred.

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- If the member is age 65 or older and has coverage under an employer group health plan with less than 20 employees either through his / her own current employment or the employment of a spouse, such coverage pays after Senior Preferred.
- If the member is under age 65 and entitled to Medicare (Senior Preferred) due to a disability (other than ESRD) and has group health coverage under an employer with two to 99 employees, either through
 - His / her own employment or the employment of a family member, Senior Preferred would be the primary payer. The employee group health coverage will be primary if the employer has 100 or more employees.
- If automobile medical or no fault liability insurance is available to the member, then benefits under that plan would be primary.
- If the member is eligible for Senior Preferred solely on the basis of ESRD and is covered under an employer group health plan, Senior Preferred pays secondary for the first 30 months with the employer plan paying primary.
- Senior Preferred may exercise the same rights to recover from a primary plan, entity or individual that the U.S. Secretary of DHHS exercises under the Medicare Secondary Payer regulations as they apply to MA plans.

4.3 SUBROGATION

Senior Preferred maintains subrogation recovery rights when claims have been paid for which a third party is liable, i.e., accidents on private property, motor vehicle accidents and nonwork-related injuries. Senior Preferred will request information from members to determine if third-party liability exists. Providers should attempt to confirm third-party liability with the member and submit claims for the medical payment amounts. When determination of liability is unresolved, Senior Preferred will pay claims and pursue reimbursement from the other carrier. Customer Service representatives are available to assist members and providers with questions and may refer you to our subrogation specialist if additional information is required.

Customer Service representatives are available Monday through Friday, 8 a.m. - 8 p.m. (800) 394-5566, TTY 711 or (800) 877-8973.

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4.4 WORKERS COMPENSATION

Senior Preferred provides no benefits for treatment, services and supplies for any illness or injury arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under Workers Compensation or Occupational Disease laws have been claimed, paid, waived or compromised.

Senior Preferred may request information from members, provider / employers in order to determine liability for a potential Workers Compensation claim. If claims are determined to be the result of a work-related injury and Workers Compensation coverage is available, regardless of whether such coverage was waived, the claims will be denied.

Workers Compensation claim denials should be submitted to our Subrogation Specialist for review. Additional information may be requested from the member and / or the provider in order to determine coverage. If medical record documentation indicates a work related injury, claims will continue to be denied and the member will be notified in writing of their appeal rights. If the medical record does not support that the injury is work related, claims will be processed pursuant to the member's Senior Preferred coverage.

If a Workers Compensation claim is filed and payment is discontinued by the carrier due to services being not medically necessary; member reaching a healing plateau; member reaching maximum medical benefit, etc.; and, medical records will be requested and reviewed to determine if treatment beyond the cutoff date was due to the work injury. If further related treatment was provided after the carrier has discontinued payment, claims will be denied and a letter will be sent to the provider informing them of their appeal rights. The provider will be instructed to appeal the denial with the workers compensation carrier, in accordance with Wisconsin Statute 102.16. If it is unclear as to whether treatment is related, a Medical Director will review all pertinent documentation to make a determination.

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4.5 NON-COVERAGE SPECIFICS

Senior Preferred HMO Limitations and Exclusions

Any services not provided or arranged for by a Senior Preferred participating provider or approved in advance by Senior Preferred are not covered by Senior Preferred. Urgently needed care outside of the service area, emergency services anywhere, or renal dialysis services provided when temporarily outside the service area is a covered benefit.

Benefits are subject to change and verification of benefits should be directed to the Senior Preferred Customer Service representatives at (800) 394-5566 or TTY 711 or (800) 877-8973. Copies of member's Evidence of Coverage (EOC) are available upon written request.

4.6 Pre-Service Denials

Notice of Denial of Medical Coverage

To comply with CMS rules, Senior Preferred must cover everything Medicare Part A and Part B covers. If a service is not covered by Medicare Fee-for-Service, it will not be covered by Senior Preferred and will be listed as an exclusion in the Senior Preferred member's benefit plan. You can find a list of benefit exclusions on the Senior Preferred website at SeniorPreferred.org/for-providers.

As a contracted provider, CMS considers you to be an agent of Senior Preferred. Contracted providers are responsible for knowing what is or isn't covered under Medicare. You have a responsibility to coordinate care with Senior Preferred prior to providing a service or referring a member to another provider. The member must be fully informed if the service they are about to receive is non-covered.

Notifying Members When a Service is Not Covered

When an item or service is not covered, you must notify the member by issuing them a notice. First check the Exclusions List located at SeniorPreferred.org/for-providers and follow the criteria below.

- If the item or service is "clearly" always excluded from coverage, explain to the member that their EOC states that the item or service is not covered and payment will be 100 percent their financial responsibility. No notice needs to be issued, you are required to inform the member verbally that there is a "clear" exclusion and place documentation in the member's medical record. There is no need to file a claim for excluded items or services that are always non-covered, unless requested by the member to do so. Should you file a claim, a GY modifier is required to be used.

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- If an item or service is not “clearly” always excluded from coverage, or if it could be non-covered sometimes, the provider must explain to the member that the item or service may not be covered by Senior Preferred and issue a pre-service notice of non-coverage and retain a copy in the patient record for future retrieval.
 - Senior Preferred utilizes the Notice of Denial of Medical Coverage, Form CMS 10003-NDMCP, which can be found along with instructions on our website at SeniorPreferred.org under Benefit Denial Forms. These forms must be issued to the member prior to providing a non-covered item or service to the member. A copy of the notice is required to be kept in the member’s medical record.
 - Your other option is to contact Senior Preferred Customer Service at **(800) 394-5566** and ask for a pre-service organization determination prior to providing a non-covered service to the member.
 - After issuing the notice, the claim should be filed to Senior Preferred with a GA modifier attached to the item or service that is non-covered.
 - If a contracted provider provides a non-covered item or service that is not “clearly” always excluded from coverage and does not issue a pre-service notice of non-coverage or obtain a pre-service decision from Senior Preferred prior to the service or item being provided, the claim will be denied as provider liability and you will not be able to bill the member for any portion of the denied claim.

Do not use the Medicare Advanced Beneficiary Notices (ABNs) or ABN-like notices

No ABNs and ABN-like notices shall be utilized with Senior Preferred members. An ABN or ABN-like notice is not a valid notice for Senior Preferred members. ABNs can only be utilized with fee-for-service Medicare beneficiaries. Use of these forms means your claim may go to provider liability. You are required to use the Notice of Denial of Medical Coverage form as described above.

How do providers bill to show appropriate notice of non-coverage was provided?

When billing for non-covered services, providers can demonstrate that they issued an appropriate Notice of Medical Coverage, Form CMS 10003-NDMCP by utilizing one of the following modifiers –

- GY modifier: In the event you file a claim for items or services that are “clearly” always excluded, use the GY modifier to show that the service or item was “clearly” excluded under the member’s Senior Preferred EOC. If the member appeals any claim associated with a GY modifier and either there is no exclusion in the member’s EOC or the exclusion is “not clear,” the claim will be reversed and denied as provider liability. You can also utilize the GY modifier if the member

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refuses to wait to receive an organization determination in favor of having the service completed immediately. You are required to place documentation in the medical record that the member refused to obtain an organization determination and elected to obtain the service or item immediately.

- GA modifier: For items or services that are not always “clearly” excluded from coverage use the GA modifier to show that appropriate notice of non-coverage (CMS-10003-NDMCP) was provided to the member. If the member appeals a claim associated with a GA modifier and there is no proof that the provider issued the appropriate notice of non-coverage, the claim will be reversed to provider liability and you will not be able to bill the member for any portion of the denied claim.

SECTION 5: PHARMACY

5.1 Introduction to the Pharmacy Program Services

5.2 Prescription Drug Formulary

5.2a Non-Covered Drugs

5.2b Generic Dispensing Policy

5.2c Restrictions/Limitations

5.3 Exception Process

5.3a Standard Coverage Determination Requests

5.3b Expedited Coverage Determination Requests

5.3c Failure to obtain Drug Prior Authorization

5.1 INTRODUCTION TO PHARMACY PROGRAM SERVICES

Senior Preferred’s Pharmacy Program oversees the operation and administration of the prescription drug benefit program for Senior Preferred members. Our Pharmacy Program is staffed with a clinical pharmacy director, pharmacy manager and pharmacy specialists, who all work closely with our Pharmacy Benefit Manager to develop policies and procedures that meet all federal and state regulatory requirements.

The Pharmacy Program also monitors formulary compliance, coordinates prescription authorization activities and monitors utilization of pharmacy services. In addition, Pharmacy Management analyzes new pharmaceuticals and oversees the drug formulary, reviews drug utilization information in order to promote rational, safe and cost effective drug therapy for the members. All of these processes are done in accordance with CMS

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regulations, National Committee for Quality Assurance (NCQA) and Health Care Effectiveness Data and Information Set (HEDIS®) standards.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

It is the expectation of Senior Preferred that all plan providers review, cooperate and participate with the Pharmacy Management requirements outlined below and assist members with understanding of any requirements and responsibilities.

Pharmacy Program inquiries should be directed to –

Senior Preferred
Pharmacy Program
840 Carolina Street
Sauk City, WI 53583
Fax: (608) 881-8398 and effective 1/1/19 (858) 357-2523
Telephone: (800) 394-5566.

Please refer to Section 2.1 for Senior Preferred HMO business hours. In situations where a member's life or health is in serious jeopardy and it is after regular business hours, a weekend or holiday; you may contact the PBM directly for immediate assistance.

5.2 PRESCRIPTION DRUG FORMULARY

The formulary is a list of medications identified by Senior Preferred HMO interdisciplinary Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is composed of physicians, pharmacists, nurses, and other health care professionals. These committee members work in collaboration to establish and maintain the drug formulary and review drug utilization information in order to promote rational, evidence-based, safe and cost-effective drug therapy for Senior Preferred HMO members, while also adhering to CMS guidelines.

The formulary applies to outpatient Part D prescription medications dispensed by participating pharmacies. Drugs requiring the assistance of a medical professional (office-based injectables) are not covered under the pharmacy benefits. Medically necessary office-based injectables are covered under the major medical benefits and may be subject to Prior Authorization review for medical necessity.

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Providers may request that the P&T Subcommittee review a new or existing medication by sending that request in writing to the Senior Preferred HMO Health Plan Pharmacy Management Department. The request may be reviewed and presented at the next quarterly P&T Committee meeting. If it is determined the drug was reviewed at the P&T Committee within the past year of the request, a new review will not be done until the following year.

New medications recently approved by the U.S. Food and Drug Administration (FDA) may be excluded from coverage until reviewed and approved by our P&T Committee. Unless excluded by the benefit or benefit design, only drugs with an FDA approved indication and Compendia approved indications will be eligible for coverage.

Experimental or investigational drugs prescribed by a physician for the treatment of HIV infection or a medical condition arising from or related to HIV infection are covered if the drug is in, or has completed a Phase III clinical investigation. Such investigation must have been performed according to federal regulations. The drug must be prescribed and administered in accordance with the treatment protocol approved for it under federal regulations.

Our Senior Preferred HMO Formulary has a five-tier design –

- Tier 1 – Preferred generic medications
- Tier 2 – Generic medications
- Tier 3 – Preferred brand name and select generic medications
- Tier 4 – Non-Preferred brand name and select generic medications
- Tier 5 – High Cost / Specialty Medications

The Senior Preferred HMO drug formulary is available on the Senior Preferred website at SeniorPreferred.org/for-providers.

Senior Preferred HMO strongly encourages the use of generic drugs and preferred brand formulary drugs for members. The P&T Committee will monitor and contact practitioners who prescribe nonformulary drugs to request consideration of formulary alternatives.

Senior Preferred HMO plan is unable to consider a Drug Prior Authorization request for drugs that are specific benefit exclusions. Some examples are listed below in the non-covered drugs section.

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5.2a Non-Covered Drugs

Here are three general rules about drugs that Medicare drug plans will not cover under Part D –

1. Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the FDA.
 - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the *American Hospital Formulary Service Drug Information*, the *DRUGDEX Information System* and the *USPDI* or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans –

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs covered under Part D that may be self-administered in a hospital outpatient setting such as emergency room, observation unit and surgery center or pain clinic if not required for the medical condition being treated. You will need to bring all of your medications with you.

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5.2b Generic Dispensing Policy

Senior Preferred encourages the use of generic drugs when available since they have the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

In the event that a brand name drug is necessary and not on our formulary, an exception request may be submitted for review. Please follow the instructions in Section 5.3.

5.2 c Restrictions / Limitations

Some covered drugs may have additional requirements or limits on coverage. More detailed information about these restrictions / limitations, such as criteria for coverage, can be found on our website at SeniorPreferred.org/for-providers. These requirements and limits may include –

- **Prior Authorization.** To promote the most appropriate utilization, selected high-risk or high-cost prescriptions or devices require Prior Authorization. The criteria necessary for a Prior Authorization is established by our P&T Committee. These medications are identified on our searchable formulary via our website.
- **Step Therapy.** -Certain prescription drugs may be subject to step therapy, which means a member must try and fail a drug(s) listed in the first-line category before we will consider coverage of the second-line drug. Several drug classes require step therapy where generics or lower cost brand name drugs are available and equally effective. If there is medical documentation to indicate that the first line drug was unsuccessful, or that members are unable to attempt a trial of first line drugs, practitioners may submit an exception request along with medical documentation for review.
- **Quantity Limits.** Some medications may have a quantity limit per prescription fill and / or per month supply. Medications with a quantity limit are identified on the formulary. One copayment and / or coinsurance will apply to each prescription fill.

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5.3 EXCEPTION PROCESS

As described above, certain prescription drugs, as determined by Senior Preferred's P&T Committee, require prior authorization and may be subject to quantity limits or step therapy. A Prior Authorization or an exception request is a type of coverage determination. You may ask Senior Preferred HMO to make an exception to the coverage rules in a number of situations –

1. Covering a Part D drug that is not on the Senior Preferred HMO formulary.
 - If the exception request is approved, the drug will be placed on the appropriate tier level. For example, brand name drugs will be placed on tier 4, non-preferred brand tier and generic will be placed on tier 2, generic tier.
 - Also, it is important to note that we are unable to consider exception requests on any “excluded drugs” or other non-Part D drugs which Medicare does not cover. Please refer back to Section 5.2a within the pharmacy information for a list of non-covered drugs.
2. Removing a restriction or limitation on a covered Senior Preferred HMO formulary drug. The restrictions would include the following –
 - Getting plan approval in advance; this is also referred to as Prior Authorization.
 - Requirements to try a different drug first before we will agree to cover the requested drug; this is also known as step therapy.
 - Restriction on the amount of drug that is allowable; this is known as quantity limits.
 - Please note: If we agree to make an exception and waive a restriction, you may also ask for a tiering exception.
3. Changing coverage of a drug to a lower cost-sharing tier for a member.
 - If the drug you are prescribing is in a non-preferred tier level, you may request that we lower the cost-sharing for the member and place it at a preferred tier level. In other words, a non-preferred brand at tier 4 may be requested for coverage at the preferred brand level and a generic at tier 2 may be requested for coverage at the preferred generic level.
 - No tiering exception requests can be considered for any drug in the tier 5-Specialty or High Cost medication tier. Also, if the drug was approved under a formulary exception, no further tiering exception can be considered.

Typically, our Senior Preferred HMO formulary includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting, we will generally *not* approve your request for an exception.

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The practitioner must submit a statement supporting for the exception request. In order to help Senior Preferred HMO make a decision more quickly, the supporting medical information should be sent with the exception request.

If the exception request is approved, the request is usually valid for one year from the date of approval, as long as you continue to prescribe the drug for the patient and it continues to be safe and effective for treating their condition. If your exception request is denied, you may appeal the decision. Grievance and appeal rights are included with all denial notices.

5.3a Standard Coverage Determination Requests

A standard coverage determination decision will require us to give the member oral or written notification determination no later than 72 hours after the receipt of the request including supportive documentation. The coverage determination form can be located on the website at SeniorPreferred.org/for-providers. These forms, with supporting medical documentation will need to be completed and directed to our Pharmacy Program using the below address / fax –

Senior Preferred
Pharmacy Program
840 Carolina Street
Sauk City, WI 53583
Fax: (608) 881-8398
Telephone: (800) 394-5566

Requests will be reviewed by the appropriate pharmacy staff. All denials will be reviewed by the pharmacy director or a medical director. Senior Preferred HMO does not allow financial incentives to staff or health care practitioners / providers at any time. All utilization management decisions are based only on the appropriateness of care and services and the existence of coverage. No practitioner, provider or individual will be rewarded for issuing denials of coverage, service or care.

5.3b Expedited Coverage Determination Requests

An expedited coverage determination may be requested when the practitioner believes that waiting for a standard decision time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy. If approved, a decision will require us to give the member oral or written notification no later than 24 hours after the receipt of the request including supportive documentation. To obtain authorization for coverage of a prescription requiring Prior Authorization in an urgent care situation,

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you may contact our Pharmacy Program toll-free at (800) 394-5566. You may also use the coverage determination request forms found online at SeniorPreferred.org/for-providers.

Denials

The Senior Preferred provides the practitioner information to understand and decide whether to appeal a decision to deny coverage. The following information is included in all denial notices –

- The specific reason or reason(s) for the denial, in easily understandable language
- Reference to the specific plan provisions, guideline, or protocol on which the denial is based.
- Instruction for filing a grievance / appeal regarding the denial and independent external review (if applicable)

Also included in the letter will be notification that members and practitioners may obtain a copy of the criteria, clinical guidelines, or benefit provisions used for making the decision. Please contact us by phone at (800) 394-5566 or (608) 881-8739, or send your request to us at the following address –

Senior Preferred
Pharmacy Program
840 Carolina Street
Sauk City, WI 53583

Senior Preferred is staffed with a full time Clinical Pharmacy Director who is able to discuss medical necessity decisions. In the event they are unavailable, Senior Preferred also staffs a medical director and associate medical directors to address questions regarding determinations.

5.3c Failure to Obtain Prior Authorization

Failure to obtain Prior Authorization will result in denial of the claim as patient responsibility. Providers / practitioners are subject to plan guidelines and under certain circumstances, or contractual obligation, the services may be denied as provider / practitioner responsibility.

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SECTION 6: PRIMARY CARE PHYSICIAN

- 6.1 Primary Care Physician Model of Care
- 6.2 Primary Care Physician Criteria
 - 6.2a Credentialed Medicare Certified Practitioner
 - 6.2b Responsible for Coordination of Overall Health Care Services
 - 6.2c Primary Care Physicians will be Classified in any Member Listing
 - 6.2d Criteria for Specialists as Primary Care Physician
- 6.3 Health Risk Assessments
- 6.4 Notice of Primary Care Physician Practice Change
 - 6.4a Primary Care Physician
 - 6.4b Transfer of Member Care
- 6.5 Practitioner Responsibilities
 - 6.5a Practitioner Responsibilities
- 6.6 Identification of Members
 - 6.6a Senior Preferred HMO Responsibilities
 - 6.6b Practitioner/Provider Responsibilities for Verification of Payer

6.1 PRIMARY CARE PHYSICIAN MODEL OF CARE

The Primary Care Physician has the primary responsibility for coordinating the overall health care for Senior Preferred HMO members. The Primary Care Physician is responsible for the coordination of the member's care to assist in improving quality and ensuring appropriate utilization of health care services. Primary Care Physicians are expected to provide appropriate care within their areas of expertise. The member shall choose a Primary Care Physician from a list provided by Senior Preferred HMO.

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6.2 PRIMARY CARE PHYSICIAN CRITERIA

The Primary Care Physician will be:

6.2a Credentialed Medicare Certified Practitioner (Medical Doctor or Doctor of Osteopathy, and for Physician Assistant or Advanced Practice Nurse as indicated by medical group partner) in one of the following disciplines: Family Practice; General Practice; General Medicine; or Women's Health or specialists as defined in Section 6.2d and practicing in the Senior Preferred HMO service area.

6.2b The Primary Care Physician is Responsible for Coordination of Overall Health Care Services Including –

- Routine health maintenance checks.
- Preventive care screening services.
- Discussion of treatment options including risks, benefits, consequences of treatment and non-treatment, and consideration of patient's desire to execute or follow an advance directive (including option of no treatment).
- Immunizations and counseling regarding health maintenance.
- Evaluation and treatment of acute illness.
- Evaluation and treatment as appropriate for specific chronic illnesses.
- Coordination of acute and chronic disease care.
- Referrals to consulting practitioners when services or consultations are necessary outside the scope of the Primary Care Physician's area of expertise (in- and out-of-network).
- Routine review and monitoring of the continuity and coordination of care furnished to members.
- Coordination of member care with skilled nursing facilities, home health, hospice and hospital care services.
- Active participation in member care with care managers, disease state management programs and other care management activities.
- Allowing the member to participate in decisions regarding their health care and treatment options.

6.2c Primary Care Physicians will be Classified in any Member Listing as –

- **Open Status:** Practitioner available to see new patients within three weeks.
- **Established Status:** Practitioner available to see established patients within four weeks. Established patients are defined as patients that have received non-urgent care services from the practitioner within the past three years.

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6.2d Criteria for Specialists as Primary Care Physician

A specialist or subspecialist may be a Primary Care Physician based on the following guidelines –

- Chronic disease states that may warrant continuation and coordination of care by a specialist. For example, congestive heart failure, diabetes and chronic renal failure.
- Documented historical (three years or more) patient / practitioner relationship where continuity in that relationship would be in the best interest of patient care.
- If the specialist practices in a multi-specialty setting, all members of the specialty who may provide coverage must agree to provide and / or coordinate the care for the member in the Primary Care Physician's absence.
- Specialists acting as a Primary Care Physician will be responsible for overall coordination of health care services as listed above with the following exceptions:
 - The specialist may refer to another practitioner for care falling outside of the specialist's scope of practice.

Specialists will be listed in the Provider Directory under their practice specialty. Specialists will not be designated on the Primary Care Physician listing that the member receives at the time of enrollment.

- A member may request a practitioner outside of the Primary Care Physician listing at the time of enrollment.
- The Provider Relations department will coordinate the member request with the requested practitioner.
- The practitioner will be asked to submit a request as verification of the specialist's ability and willingness to act as the Primary Care Physician for individual members.

6.3 HEALTH RISK ASSESSMENTS

A Health Risk Assessment (HRA) is offered to all Senior Preferred members to establish health care needs. HRA results assist in identifying members with complex or serious medical conditions and / or depression, as well as those who would like information about setting up an Advance Directive. HRA results also assist in the identification of members who may benefit from Disease Management services and / or complex case management (CCM) services.

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6.4 NOTICE OF PRIMARY CARE PHYSICIAN PRACTICE CHANGE

The Provider Relations department must be notified of any practice changes. It is the practitioner's responsibility to submit written documentation to the department for notification of any such changes by sending an email to the provider network administrator.

6.4a Primary Care Physician

Continuity of care and a stable network of providers are necessary to assure timely access and appropriate care for members. In the event of extenuating circumstances and with the Senior Preferred HMO Medical Director's approval, a Primary Care Physician shall be able to change his or her status as a Primary Care Physician.

Primary Care Physicians are required to notify the Provider Relations department in writing at a minimum of 60 days in advance regarding the following status changes –

- Change from Open status to Established status;
- Change from Established status to Open status;
- Retirement, leave of absence, resignation, termination or any change in practitioner practice which impairs the provider to carry out their responsibilities; and
- Practitioners who have previously terminated status as Primary Care Physicians and wish to reactivate this status shall be required to request a status change in writing to Senior Preferred HMO for Medical Director approval.

Upon receipt of request for change in status, the request shall be reviewed by designated Senior Preferred staff. The Medical Director will then make the final determination whether the practitioner or contracted facility can continue to meet the Senior Preferred HMO access standards for members.

6.4b Transfer of Member Care

In the event of a change in practice status, practitioners are required to assist Senior Preferred HMO with transition of member care.

It is the contracted facility or practitioner's responsibility to assure effective communication with members regarding the transfer of the member's care to another practitioner.

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Activities associated with transition of member care include –

- Identify and communicate with the practitioner who will be designated as the member's Primary Care Physician. Accepting practitioner must meet criteria for a Primary Care Physician status as previously outlined.
- Effective date of anticipated transfer of care.
- Identification of members in high-risk categories (chronic disease states, members utilizing care management services).
- Assist members in transferring medical record and treatment plan information to accepting practitioner.

In the event the practitioner cannot assist in the transfer of care, Senior Preferred HMO is required to identify a suitable practitioner for members who have not indicated a preference.

- Senior Preferred HMO, through review of its panel of Senior Preferred HMO participating practitioners, will assist members in transition of their care to an appropriate practitioner.
- Senior Preferred HMO will be responsible to notify members and other parties in regard to any practitioner status changes.
- If you require assistance with this process, please contact your provider coordinator.

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6.5 PRACTITIONER RESPONSIBILITIES

- The Primary Care Physician and other treating practitioners will review information provided by Senior Preferred HMO in order to maximize the member's health status and evaluate the continuity and coordination of care furnished to members.
 - Patient's compliance with prescribed treatments or regimens, based on record review and administrative data.
 - Identify and avoid duplication in diagnostic or laboratory testing.
 - Identify and coordinate opportunities for wellness programs.
 - Identify and coordinate community resources and social services.
 - Identify and coordinate patient's eligibility and appropriateness for participation in case management or disease management programs (high-risk, chronic disease, frequent hospitalizations, increased utilization of ambulatory services).
 - Coordinate care with Care Manager for those members receiving these or related services (disease management or self-care programs).
 - Develop a treatment plan based on identified needs in the health risk appraisal and office assessment.
 - Notification in a timely manner of all abnormal critical test results. The timeliness of the notification is based upon the medical indication and urgency of follow-up care, or the need for a change in the treatment plan.
 - Notification may be communicated via letter, telephone or verbally during a follow-up appointment and will be documented in the member's medical record.
 - Practitioner will ensure appropriate and confidential exchange of patient information among treating health care professionals.
 - Practitioner is responsible to ensure that members / patients are informed of specific health care needs that require follow-up care. Members must receive training as appropriate in self-care and other measures they may take to promote their own health.
 - Practitioner is responsible for obtaining prior written authorization from the Medical Director for all out of network services.

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- Practitioner is responsible to provide information regarding treatment options in a culturally competent manner, including the option of no treatment.
- Practitioner is responsible to ensure that individuals with disabilities have effective communications throughout the health care network in order to make decisions regarding treatment options.
- Practitioner will involve the member in the development of the treatment plan, and assist the member by coordinating the services, Prior Authorization, and if necessary, referrals to Senior Preferred HMO practitioners as appropriate.

6.6 IDENTIFICATION OF MEMBERS

6.6a Senior Preferred HMO Responsibilities

- Members enrolled in Senior Preferred HMO will be provided with a member identification (ID) card. Reference Section 3.5, Member Related Information for additional member ID information. Senior Preferred HMO will provide confirmation of member eligibility upon request. Call Customer Service at (800) 394-5566 to verify member eligibility.

6.6b Practitioner / Provider Responsibilities for Verification of Payer

- The practitioner / provider shall request the member's ID card before services are provided and verify that all demographic and insurance information is correct in order to assure correct registration and reduce the possibility of confusion in the billing and reporting processes.
- The practitioner, provider or designee shall contact a Senior Preferred Customer Service representative at (800) 394-5566 any time verification of eligibility or verification of Primary Care Physician designation is necessary. The practitioner's office shall contact a Senior Preferred Customer Service representative at (800) 394-5566 or any time the practitioner or designee becomes aware of incorrect member information.

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SECTION 7: PROVIDER RIGHTS AND RESPONSIBILITIES

- 7.1 Practitioner / Provider Verification of Eligibility
- 7.2 Prohibition of Interference – Advice to Members
- 7.3 Provider Reporting of Member Complaints Process
- 7.4 Notification Process to Providers
- 7.5 Provider Contracting
 - 7.5a Agreement with Contracting and Subcontracting Entities
 - 7.5b Termination of Provider
- 7.6 Continuity of Care
- 7.7 Credentialing Process
 - 7.7a Network Participation Standards Overview
 - 7.7b Network Practitioner Criteria
 - 7.7c Facility / Organizational Participation Criteria
 - 7.7d Credentialing Staff and Committee Structure
 - 7.7e Participating Professional Review Process
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 - 7.8a Request for Exceptions
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 - 7.8c Behavioral Health Providers
- 7.9 Types of Review and Appeal Processes
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 - 7.9d Disciplinary Action Procedure
- 7.10 Standards of Conduct
- 7.11 Access Standards
- 7.12 Medical Record Documentation Audit
- 7.13 Practitioner Credentialing and Notification of Practitioner / Provider Changes

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7.1 PRACTITIONER / PROVIDER VERIFICATION OF ELIGIBILITY

- The practitioner or provider shall request the member's ID card before services are provided and verify that all demographic and insurance information is correct in order to ensure correct registration and reduce the possibility of confusion in the billing and reporting processes.
- The practitioner, provider or designee shall contact a Senior Preferred HMO Customer Service representative at (800) 394-5566 any time verification of eligibility or verification of Primary Care Physician designation is necessary.
- The Practitioner's office shall contact a Senior Preferred HMO Customer Service representative at (800) 394-5566 any time the practitioner, provider or designee becomes aware of incorrect member information.

7.2 PROHIBITION OF INTERFERENCE – ADVICE TO MEMBERS

Senior Preferred HMO advocates and upholds the patient / practitioner relationship and does not prohibit or otherwise restrict a health care professional, acting within their lawful scope of practice, from providing advice to an individual who is a patient and enrolled in the Medicare Senior Preferred HMO plan. Specifically, Senior Preferred HMO will not interfere with the communications between the provider and patient regarding –

- The patient's health status, medical care or treatment options (including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options, including no treatment as an option or any alternative treatment that may be self-administered);
- The risks, benefits and consequences of treatment or non-treatment; or
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions.

Senior Preferred HMO shall not penalize a provider because the provider, in good faith, reports to the state or federal authorities any act or practice by Senior Preferred HMO that, in the opinion of the provider, jeopardizes patient health or welfare.

7.3 PROVIDER REPORTING OF MEMBER COMPLAINTS PROCESS

In an effort to maintain patient satisfaction, regulatory and quality standards, Senior Preferred HMO participating providers are required to establish a formal mechanism for prompt response and resolution of member complaints consistent with the Senior Preferred HMO Provider Services Agreement and Plan Policy 11.218.

Provider Responsibilities:

- Document the process of complaint handling in a policy or procedure.
- Investigate and promptly respond to facilitate complaint resolution.

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- Maintain all documentation related to complaints for 10 years following resolution and make available upon request.

Plan Responsibilities:

- Promptly notify provider of the complaint received.
- Monitor complaint for timely response and resolution.
- Maintain records and reports as appropriate to monitor provider compliance.

Providers / practitioners are not required to provide any information that is privileged and confidential under the attorney-client privilege, the Attorney Work Product Doctrine or Wisconsin's Peer Review Statutes, nor shall they be required to provide any information except in accordance with laws governing confidentiality of patient and health care records and information.

Providers should direct any member complaints related to Senior Preferred HMO service issues, benefits or claims status to Customer Service at (800) 394-5566.

7.4 NOTIFICATION PROCESS TO PROVIDERS

1. Notices, amendments, addendums, consents, approvals, requests or other communication required or permitted to be given pursuant to the terms and provisions of this Agreement shall be in writing, and shall be personally delivered, sent by United States mail, or other nationally recognized mail service and postage prepaid.
 - Requests for changes in any fee or reimbursement schedule.
 - Changes regarding contract provisions.
 - Changes in state, federal or other regulatory agency requirements in which the provider will be required to comply.
 - Terminations of contractual relationships.
 - Prior authorization requirements
 - Referral guidelines
 - Billing Requirements / Terms for Payments
 - Participation standards (Provider Manual)
 - Quality improvement initiatives and performance criteria.
 - Data reporting requirements
 - Provider Manual changes
 - Grievance and appeals responsibilities and rights (member and provider).
 - Drug formulary requirements

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2. Senior Preferred HMO will provide 60 days written notice regarding changes in No. 1 of the above requirements. All notices must be received by provider 60 days prior to effective date. This will be accomplished through –
 - Certified mail
 - Hand delivery
 - Direct mailing
 - Fax
 - Website postings
 - Electronic mail
 - Internet availability
 - Provider Manual updates
 - NewsFlash

NewsFlash

A provider bulletin, entitled “*NewsFlash*” is distributed to Senior Preferred HMO participating providers and practitioners. “*NewsFlash*” is a supplement to the Senior Preferred HMO Provider Manual and will offer further clarification of current issues and regulations.

7.5 PROVIDER CONTRACTING

7.5a Agreement with Contracting and Subcontracting Entities

Where provider provides services through subcontracts with other individuals or entities, provider shall require those individuals or entities to comply with provider’s obligations under the Provider Services Agreement and as required by applicable statutes and regulations.

7.5b Termination of Provider

Consistent with all applicable regulatory requirements, Senior Preferred HMO reserves the right to terminate any provider for failure to be compliant with any of the following –

1. Senior Preferred HMO participation standards.
2. Persistent non-compliance to Senior Preferred’s policies and / or procedures.
3. Breach of the provider agreement without remedy of such breach after 30-day notification.
4. Upon receipt of written notice that provider can no longer meet the obligations required under their agreement. These include, but are not limited to suspension, revocation, or expiration of any license or certificate, which is required to perform required obligations under this contract.
5. Upon notification of bankruptcy or insolvency.

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6. Notification of any sanction, remedial actions or revocation of Medicare participation, or that of applicable state or federal agency.
7. In the event that in the judgment of the Senior Preferred HMO, continuation of the agreement would jeopardize the health and welfare of members.
8. With or without cause accompanied by appropriate written notice as designated within the Provider Services Agreement.
9. In the event provider services are no longer needed in a geographical location.

In the event of termination, Senior Preferred HMO will –

1. Notify the provider or contracting entity of termination, including effective date and when applicable –
 - Reasons for termination
 - Right to appeal decision
 - Obligations of the provider in the termination process
2. Notify Senior Preferred HMO members and coordinate transfer of member care to other Senior Preferred HMO practitioners / providers within 15 days.
3. Notify as applicable, any state, federal or regulatory agencies.

Termination of providers will be consistent with Senior Preferred HMO policies and procedures and any applicable state or federal law.

7.6 CONTINUITY OF CARE

In the event a contractual agreement is terminated for reasons other than practitioner's or provider's misconduct, the practitioner / provider shall be entitled to receive payment for services furnished to members, as required under Wisconsin Stat. §609.24, for the duration of the continuation period (defined in Wisconsin Stat. §609.24) and as specified below.

Members may continue to seek care from the inactive practitioner / provider, consistent with any state, federal and Senior Preferred requirements. Senior Preferred HMO recognizes that inactive providers / practitioners are not obligated to continue services except as required by any state or federal law. Providers / practitioners agreeing to continue care must agree to meet the continuous care standards utilized by Senior Preferred HMO.

During the continuation period, the practitioner / provider agrees to accept payment rates set forth in any contractual agreement and abide by the terms of the contractual agreement, including, but not limited to, the Hold Harmless Clause and the Senior Preferred's utilization review and quality assurance procedures. In accordance with Wisconsin Stat. §609.24, Senior Preferred's obligation to provide compensation for services furnished to a member shall only apply if Senior Preferred HMO represented to the member that the provider / practitioner was, or would be, a participating practitioner

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/ provider, participating hospital or participating agency in marketing materials that were provided or available to the member at the most recent open enrollment or renewal period.

The period in which care may be continued –

1. In the case of a practitioner (primary care physician) specializing in family practice, general practice, general medicine or specialist as described in 6.2d, a period that shall not exceed –
 - For a member of a plan with no open enrollment period: until the end of the current plan year; or
 - For a member of a plan with an open enrollment period: until the end of the plan year for which the plan represented that the physician was, or would be, a participating practitioner.
2. In the case of a practitioner from whom a member is undergoing a course of treatment who is not a Primary Care Physician, a period that shall not exceed –
 - Except as provided below, the remainder of the course of treatment or 90 days after practitioner's or provider's participation terminates, whichever is shorter; or
 - If the course of treatment is maternity care and the member is in the second or third trimester of pregnancy at the time participation terminates, until the completion of postpartum care for the woman and infant.

Coordination of continued care will be evaluated on a case-by-case basis. Any questions regarding any of the stipulations described above may be directed to Senior Preferred Provider Relations at (800) 394-5566.

7.7 CREDENTIALING PROCESS

7.7a Network Participation Standards Overview

The purpose of the Senior Preferred HMO Credentialing Program is to ensure that the Senior Preferred HMO network is comprised of appropriately credentialed practitioners and facilities (providers). Senior Preferred HMO Credentialing Program is designed to comply with NCQA standards, CMS, state and federal agencies and Senior Preferred HMO policies.

The credentialing process includes the systematic collection, verification and evaluation of information about a practitioner's education, experience, qualifications, licensure and quality of care. Unless there are clear and convincing reasons to depart from these guidelines, Senior Preferred HMO Credentialing subcommittees and staff will adhere to these guidelines.

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Senior Preferred HMO practitioners must receive credentialing approval for inclusion in the Provider Directory. Senior Preferred HMO retains the discretion to list practitioners consistent with policy.

Senior Preferred HMO practitioners must be recredentialed in order to qualify for continued network participation. This process occurs in increments of up to every three years. The recredentiaing process includes, but is not limited to a review of performance data such as utilization review, quality information and member satisfaction.

Information acquired through the credentialing / recredentiaing process is considered confidential. Senior Preferred is responsible for ensuring that all credentialing and peer review information remains confidential unless otherwise provided by law. The release of any practitioner information obtained during the credentialing / recredentiaing process is prohibited without written, signed and dated consent provided by the practitioner.

Practitioners have a right to review the documentation received by Senior Preferred HMO as a part of the credentialing process with the exception of letters of reference and peer review protected information. Practitioners also have the right to correct any erroneous information that varies substantially from information they have provided on the credentialing application and, upon request, to be informed of the status of their credentialing or recredentiaing application. Senior Preferred HMO will notify practitioners of their credentialing status within 60 days of the decision.

Senior Preferred HMO reserves the discretionary authority to deny network participation to applicants, except as otherwise dictated by law. In selecting practitioners, Senior Preferred HMO does not discriminate in terms of participation, reimbursement, or indemnification, against any health care professional that is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Furthermore, Senior Preferred HMO does not discriminate against race, ethnic / national identity, gender, age, sexual orientation, types of procedures performed, types of patients seen, professionals who serve high-risk populations or those who specialize in the treatment of costly conditions. Providers and practitioners applying for participation in the Senior Preferred HMO network shall be responsible for maintaining the participation requirements that are outlined in this Provider Manual and their Senior Preferred HMO provider contracts. If the practitioner does not maintain these requirements, Senior Preferred HMO maintains the authority to deny, suspend or discontinue their participation in the network except as otherwise required by law.

Break in Service (including military and extended medical leave)

If any practitioner in good standing ends his / her contract with Senior Preferred HMO, or who otherwise terminates his / her relationship with the plan, and later requests a new contract where there has been a break in service of 30 days or more, Senior Preferred HMO must initially credential the practitioner again before the practitioner can rejoin the

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network. Examples include, but are not limited to a return to practice after an affirmed termination from the plan by a provider or practitioner, or a leave of absence, not medical in nature.

If a practitioner(s) has been successfully credentialed as part of a new contract process, but the contracting process is not completed within 90 days, the practitioner(s) may have to be recredentialed. At a minimum, attestation dates, license and malpractice information must be re-verified.

Senior Preferred HMO will make every reasonable effort to obtain the necessary credentialing information within the specified time frames for persons in active military duty or on extended medical leave. However, if Senior Preferred HMO cannot obtain the necessary information for reasons beyond its control and the contract between Senior Preferred HMO and the practitioner remains in place, Senior Preferred HMO may recredential the practitioner upon his / her return. Documentation of the reason for the delay must be included in the practitioner's file.

At a minimum, Senior Preferred HMO must verify that a practitioner who returns from military or medical leave has a valid license to practice before he / she resumes seeing patients. Within 60 days of when the practitioner resumes practice, Senior Preferred HMO must complete the recredentialing cycle.

Locum Tenens: If a practitioner will be providing services for 60 days or less, he / she will be considered a locum tenens practitioner and must thereby meet specific Senior Preferred HMO requirements. A Senior Preferred HMO application must be completed, verified and approved by the Medical Director prior to rendering payable services to Senior Preferred HMO members. If such a practitioner intends to provide services for greater than 60 days, he / she will be subject to review and approval by Senior Preferred HMO Credentialing committees and staff.

Expedited Credentialing: At the discretion of Senior Preferred HMO, a practitioner may be considered for an expedited credentialing process whereby the practitioner will be credentialed prior to the next scheduled Credentialing Subcommittee. A practitioner can only be considered for expedited credentialing when an application is complete and all Senior Preferred HMO policy requirements are met. The Medical Director or designee (other Medical Director) thereafter has the authority to sign off on the practitioner's participation approval without full Credentialing Subcommittee or Medical Director Subcommittee review. The names of practitioners approved in this manner are included as an informational item on the agenda of the next Credentialing Subcommittee meeting following such approval. The expedited process applies only to practitioners and not to facilities.

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7.7b Network Practitioner Criteria

General Criteria for Practitioner / Provider Network Acceptance

1. Satisfy a specialty and / or geographic need identified by Senior Preferred HMO to serve its current membership.
2. Maintain the necessary facility and practice-appropriate federal and state health care license(s) or certification(s) for the state(s) in which care will be rendered.
3. Satisfy the necessary professional health care education / training specific to their specialty and type of practice.
4. MD / ODs, DPMS and DDSs must have completed a residency or be Board Certified, and are afforded three years in which to become certified in their area of specialty.
5. Certify that they are not currently opted out of, nor restricted from receiving payments from Medicare, Medicaid (any state), or third-party programs, and divulge any such previous restrictions. If previously sanctioned or reinstated, appropriate documentation is required.
6. Disclose the nature of any disciplinary actions by state or local professional societies, state licensing boards, or other agencies relative to their practice, including supporting evidence that they are in compliance with any stipulated practice conditions.
7. Disclose the history and nature of any professional liability claims or lawsuits, including pending, dismissed, or dropped claims or lawsuits, settlements or final judgments.
8. Certify that they have not been involved in sexual misconduct, sexual assault, or sexual harassment and have not been found liable, guilty or responsible for sexual misconduct or sexual harassment within their professional capacity. If previously sanctioned and reinstated, appropriate documentation is required.
9. Certify that they are not currently charged with and / or have never been convicted of a felony or gross misdemeanor.
10. Certify that previous applications for hospital privileges have not been revoked, suspended, refused, relinquished or limited by any hospital, clinic, or third-party payer. Provide all appropriate documentation if previous history includes such instances.
11. In accordance with current scope of practice, shall maintain hospital admitting privileges in good standing at a participating Senior Preferred HMO hospital. If no such privileges, Senior Preferred HMO requires a statement delineating the inpatient coverage arrangement to a Senior Preferred credentialed practitioner and facility.
12. Maintain a valid, current Drug Enforcement Administration (DEA) registration and / or Controlled Substance Registration issued by the state in accordance with scope of practice.
13. Be willing to provide or arrange for coverage seven days a week, 24 hours per day.
14. Maintain current professional liability coverage appropriate to the scope of practice in accordance with state-mandated or contractually established minimum limits.

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15. Agree to release and provide all additional information upon request throughout the credentialing process regarding practitioner performance, problem identification, or problem resolution.
16. Be able, with or without reasonable accommodation, to perform the essential functions of his or her practice with acceptable skill and without posing significant safety risk to patients.
17. Attest to the lack of present and illegal drug use.
18. Agree not to make any material misrepresentation or omissions in credentialing documents.
19. Provides explanation of any chronological gaps in recent work history of greater than six months.
20. Agree to comply with the Senior Preferred HMO administrative policies and procedures including those related to quality issues and practitioner performance review.
21. Maintain a valid and current Senior Preferred HMO Provider Service Agreement or contract.
22. Maintain appropriate licensures, certifications and billing numbers, including but not limited to, the National Provider Identifier (NPI) or its equivalent, Medicare and Medicaid numbers.
23. Office locations for all Primary Care Physicians, OB-GYNs, and High Volume Behavioral Health practitioners, must have met the Senior Preferred's site visit score requirements prior to practitioner credentialing.

Clinic Site Visits

To ensure conformity with established Senior Preferred HMO standards for network participation, a standardized structural site audit may be performed during initial application of all Primary Care Physicians, obstetricians / gynecologists and behavioral health care providers, as well as for any relocations or opening of additional sites.

Senior Preferred must ensure that all participating office sites meet performance standards and thresholds at a minimum for –

- Physical accessibility;
- Physical appearance;
- Adequacy of waiting and examining room space; and
- Adequacy of medical / treatment record keeping.

Specific Professional Participation Criteria

In addition to the general criteria for network participation listed in the previous section, Senior Preferred HMO requires the following specific criteria by discipline. These represent minimum network qualifications with additional factors also considered. Providers and practitioners shall be responsible for and shall have the burden of proof with regard to demonstrating that all requirements have been met.

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MEDICAL DOCTORS (M.D.) and DOCTORS OF OSTEOPATHY (D.O.):

- Graduation from an accredited school of medicine or osteopathy.
- Foreign Medical School Graduates shall also be asked to provide a copy of the Educational Commission for Foreign Medical Graduates (ECFMG).
- Have a valid, current medical license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- **Medical Doctors:** Completion of a residency and be board certified or actively pursuing board certification in the specialty in which (s)he practices by an American Board recognized by the American Board of Medical Specialties (ABMS), or other NCQA recognized boards. Equivalent experience will be considered for those completing professional training before January 1, 1980. (Defined as: one year of post-medical school training; a.k.a. internship or first year of three-year residency.)
- **Doctors of Osteopathy:** Completion of a residency and be board certified or actively pursuing board certification in the specialty in which (s)he practices by the American Osteopathic Association (AOA). Equivalent experience will be considered for those completing professional training before January 1, 1980. (Defined as: one year of post-medical school training, a.k.a., internship or first year of three-year residency.)
 - A 60-day provisional credentialing status will be allowed for physicians who have completed their Residency or Fellowship within the 12 months just prior to recredentialing decision, so long as all other credentialing criteria are satisfied and the Residency or Fellowship can be verified within 60 days of the decision.
 - General Criteria as listed in previous Section 7.7b specific to scope of practice.

PODIATRISTS (D.P.M.)

- Graduation from an accredited college of podiatric medicine.
- Completion of a one- to three- year podiatric residency program or active hospital-related practice for the last five years.
- Be board certified or actively pursuing board certification by the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, depending upon their area of specialty. Equivalent experience will be considered for those completing professional training before January 1, 1980. (Defined as: one year of post-medical school training.)
- Have a valid, current podiatric license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- A 60-day provisional credentialing status will be allowed for physicians who have completed their Residency or Fellowship within the 12 months just prior to credentialing decision so long as all other credentialing criteria are satisfied and the Residency or Fellowship can be verified within 60 days of the decision.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

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PSYCHOLOGISTS (Ph.D.) or (Psy.D.)

- Completion of a doctoral degree in psychology.
- Completion of an American Psychological Association approved internship or equivalent internship approved by the National Register of Health Service Providers in Psychology or certification by the American Board of Professional Psychology.
- Have a valid, current doctoral level license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.
- **Important:** You must also refer to Section 7.8c for further information about Behavioral Health Provider Participation Requirements.

OTHER BEHAVIORAL HEALTH PROVIDERS –

- **Midlevel Behavioral Health Professionals:** Must hold one of the following licenses for the state(s) in which the practitioner will see Senior Preferred members –
 - Licensed Clinical Social Worker (LCSW) – Wisconsin
 - Licensed Independent Clinical Social Worker (LICSW) – Minnesota
 - Licensed Independent Social Worker (LISW) – Iowa
 - Licensed Professional Counselor (LPC) – Minnesota and Wisconsin
 - Licensed Psychologist, (LP Level II) (Ph.D. Psychologist in Minnesota)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Alcohol and Drug Counselors (LADC)
 - Licensed Mental Health Counselor (LMHC)
 - Licensed Clinical Substance Abuse Counselor
 - Registered Nurse Clinical Nurse Specialist – Behavioral Health / Psychiatry_– also must meet all criteria as noted in the Nurse Practitioner section below.
 - Completion of a Master’s or Ph.D. degree in field of practice.
 - General Criteria as listed in previous Section 7.7b, specific to scope of practice.
 - Important: See Section 7.8c Behavioral Health Provider Participation Requirements.

PHYSICIAN ASSISTANTS — Certified (P.A.-C.)

- Graduation from an accredited Physician Assistant course (B.S. or M.S.)
- Practice under the supervision of / collaboration with a Senior Preferred participating physician.
- Maintenance of certification by the National Commission on Certification of Physician Assistant (NCCPA), or the National Board for Certification of Orthopedic Physician Assistant.

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- Have a valid, current physician assistant license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- DEA registration required if practicing in a setting where a DEA registered physician is not present.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

NURSE PRACTITIONERS (N.P.)

- Graduation from an undergraduate accredited school of nursing.
- Completion of Master's Degree in Nursing (MSN) required for those achieving NP status after July 1, 1998; or,
- Certificate from an accredited Nurse Practitioner program for those achieving NP status before July 1, 1998.
- Practice under the supervision of a Senior Preferred HMO participating physician.
- Maintenance of Certification in a specialty area through a nationally recognized certifying board such as American Nursing Credentialing Center, American Association of Nurse Practitioners.
- Maintain a valid, current registered nurse license for the state(s) in which the practitioner will see Senior Preferred HMO members. The rules of any applicable state nursing compact agreements will be honored.
- **Wisconsin:** Maintain an Advanced Practice Nurse Prescriber certificate.
- **Iowa:** Maintain an Advanced Registered Nurse Practitioner license to practice independently.
- **Minnesota NP's:** no additional specific licensure beyond RN applies, but they must have a specialty certification.
- DEA registration required if practicing in a setting where a DEA registered physician is not present.
- Senior Preferred HMO recognizes that specialty training may vary by state and date of completion and will evaluate on a case-by-case basis.
- Behavioral Health Nurse Practitioners must obtain and maintain certification through the ANCC specialty of Adult Psychiatric and Mental Health Nurse Practitioner.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

CERTIFIED NURSE MIDWIVES (C.N.M.)

- Graduation from an accredited school of nursing.
- Graduation from an accredited college of nurse midwifery, or other advanced nursing practice program (as described above).
- Maintenance of Certification in midwifery through a nationally recognized certifying board such as American Nursing Credentialing Center, American Association of Nurse Practitioners.
- Maintain a valid, current license for the state(s) in which the practitioner will see Senior Preferred HMO members. The rules of any applicable state nursing compact agreements will be honored.

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- **Wisconsin:** Maintain an Advanced Practice Nurse Prescriber certificate.
- **Iowa:** Maintain an Advanced Registered Nurse Practitioner license to practice independently.
- **Minnesota Nurse Midwives:** no additional specific licensure applies, beyond specialty certification.
- DEA registration required if practicing in a setting where a DEA registered physician is not present.
- Practice under the supervision of / collaboration with a Senior Preferred HMO participating physician.
- General Criteria as listed in previous section 7.7b specific to scope of practice.

OPTOMETRISTS (O.D.)

- Graduation from an accredited college of optometry.
- Maintain a valid, current optometric license and Diagnostic Drug Certification for the state(s) in which the practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous section 7.7b specific to scope of practice.

DENTISTS (D.D.S. / D.M.D.) - Dental Specialists and Surgeons –

- Diploma or equivalent from an accredited school of dentistry.
- Successful completion of accredited residency program in specialty area, if applicable.
- Board Certification in specialty area from The American Board of Oral Maxillofacial Surgery (Oral Surgeons only).
- Have a valid, current DEA registration, as applicable.
- Maintain a valid, current license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

PHYSICAL THERAPISTS (P.T.)

- Diploma from an accredited school of physical therapy (B.S. or M.S.)
- Maintain a valid, current license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

CHIROPRACTORS (D.C.)

- Graduate of a college of chiropractic medicine that is accredited by the Council on Chiropractic Education.
- Maintain a valid, current license for the state(s) in which the practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous Section 7.7b specific to scope of practice.

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AUDIOLOGISTS

- M.S. or Doctorate (Au.D.) in Audiology with a completed supervised clinical practicum, or equivalent, as approved by license examining board.
- Evidence of having passed the examination required for certification as an audiologist by American Speech Language – Hearing Association, or equivalent, as approved by license examining board (Certificate of Clinical Competence – CCC).
- Completion of postgraduate professional clinical experience in audiology, or equivalent, as approved by license examining board.
- Maintain a valid, current license for the state(s) in which practitioner will see Senior Preferred HMO members.
- General Criteria as listed in previous Section 7.6b specific to scope of practice.

HOSPITAL BASED PRACTITIONERS – NOT CREDENTIALIED

- Other hospitalist practitioners who will not be providing care in a clinic setting including, but not limited to advance practice nurses (including certified registered nurse anesthetists); physician assistants - certified; physical therapists; certified anesthesiology assistants; moonlighting residents in urgent care; emergency room physicians and pathologists. These practitioners are required to complete an abbreviated, but defined process before receiving Senior Preferred HMO payable status approval by the Medical Director. Specific requirements can be obtained by contacting the Provider Relations Credentialing.

Senior Preferred HMO also reserves the right to review practitioners, including but not limited to, those types named above and can decide at any time to bring a hospitalist or a short-term locums practitioner's file to the Credentialing Subcommittee for a decision.

- Other potential network practitioners must have a current license / certification and training appropriate to their scope of practice.

7.7c Facility / Organizational Participation Criteria

Senior Preferred HMO requires initial credentialing of facilities as a condition of contracting followed by a recredentialing process at least every three years. These requirements apply to the following facility types: hospitals; home health agencies; skilled nursing facilities; nursing homes; freestanding surgery centers and behavioral health facilities providing behavioral health or substance abuse services in an inpatient, residential or ambulatory setting. Other contracted facilities can be reviewed at Senior Preferred's discretion.

The following criteria will be required for facility participation in the Senior Preferred HMO network.

- Providers must complete a credentialing application prior to contracting, and review, update, and approve this information at the time of recredentialing and upon request.

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- Senior Preferred HMO will conduct an initial assessment of the facility prior to contracting for member services. All criteria must be satisfied and approved by the Senior Preferred HMO Credentialing Subcommittee, Medical Director Subcommittee, and Board of Director's before contracting can be finalized.
- Prior to contracting, Senior Preferred HMO will request and verify that the facility has –
 - Met all appropriate regulatory requirements
 - Provided copies of current state licensing or certification
 - Provided evidence of current Medicare and Medicaid certification, including provider numbers
 - Attested that licenses are current and free of restrictions, limitations, or sanctions
 - Attested that there are no sanctions of any nature against them by any government program
 - Attested to the existence of current and adequate facility malpractice insurance.
 - **For hospitals only:** Have submitted copy of a Medical Staff Service Plan, or equivalent, attesting that there is a formalized process for verifying the credentials of the medical staff who provide services to members. At a minimum, the staff must be legally and professionally qualified for the positions they hold.
 - Been approved by a recognized accrediting body recognized by Senior Preferred HMO including the following –
 - TJO – The Joint Commission
 - AAAHC – Accreditation Association of Ambulatory Health Care
 - CARF – Commission on Accreditation of Rehabilitation Facilities
 - CCAC – Continuing Care Accreditation Commission
 - CHAPS – Community Health Accreditation Program
 - DNV Health care Inc. – Det Norske Veritas Health care, Inc.
- Accrediting bodies other than those listed above may be reviewed and deemed appropriate or required by Senior Preferred HMO.
- If the facility has not been approved by an accrediting body, Senior Preferred HMO will instead accept a State Survey report, Critical Access Hospital Survey, or a Medicare (CMS) Survey. Senior Preferred HMO will request the full report from the facility for verification.
- If the facility has not been approved by an accrediting body and does not have an equivalent State, Critical Access or Medicare report, or is not in good standing with an accrediting body, Senior Preferred HMO would determine the facility's suitability for participation before proceeding further.
- At the time of recredentialing (at least every three years), Senior Preferred HMO will confirm that the facility –
 - Continues to be in good standing with state and federal regulatory bodies.

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- Maintains current licensure and / or certification.
 - Is still approved and in good standing with the appropriate accrediting body and / or surveying regulatory agency.
 - Provides updated attestations stating that licenses are current and free of restrictions, limitation, or that there are no sanctions of any nature against them by any government program and that liability insurance is current and adequate.
 - For hospitals: Continues to follow Medical Staff Services policy guidelines to assure that staff are both legally and professionally qualified for the positions they hold.
- Senior Preferred HMO reserves the right to establish a reasonable time frame for correction of any deficiency in a facility and to determine the facility's suitability for continued participation.
 - Facilities will be required to provide information regarding professional liability claims that have been filed and / or adjudicated against the provider / facility within the past year.
 - Facilities must maintain liability and malpractice insurance that is appropriate to level of services provided or as required by contract.
 - Senior Preferred HMO reserves the right to review quality improvement activities.
 - Network providers / facilities must cooperate with the Senior Preferred HMO quality management activities.
 - The facility must not have made any material misrepresentations to Senior Preferred HMO concerning licensure, registration, certification, disciplinary history, or any other material matter covered in the application or credentialing materials.
 - Providers must maintain a valid Senior Preferred HMO contract or Provider Service Agreement. Additional on-site review audits, or exceptions will be evaluated on a case-by-case basis. Senior Preferred HMO reserves the right to conduct an on-site Facility Quality Review or Credentialing at any time either prior to or after contracting to determine suitability for participation, including when there is a change in ownership.

7.7d Credentialing Staff and Committee Structure

Senior Preferred HMO Credentialing Staff

Credentialing staff includes the manager and credentialing administrator in the Provider Relations department. The Provider Relations department is the primary contact for facilities and practitioners. The application, primary source verification and quality information is summarized and reviewed by the department staff for Credentialing Subcommittee review. The Credentialing staff is also responsible for establishing and implementing credentialing and recredentialing policies and procedures.

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Any credentialing or recredentialing application information, as well as new, revised or reviewed policy and procedure information, shall be forwarded by credentialing staff to the Credentialing Subcommittee.

To contact any member of the Credentialing staff, call (608) 881-8233.

Credentialing Subcommittee

The Credentialing Subcommittee is a standing committee that meets at least once per month. The Credentialing Subcommittee members are a diverse group of medical practitioners who review and recommend approval or denial for credentialing and recredentialing applicants. The Subcommittee is also responsible for recommendations regarding new, reviewed and revised policies related to credentialing and provider participation standards. The Credentialing Subcommittee recommends credentialing and recredentialing and policy approval to the Medical Director Subcommittee. Any questions regarding activity conducted by the Credentialing Subcommittee can be directed to Senior Preferred HMO credentialing staff.

The Medical Director Subcommittee

The Medical Director Subcommittee is a standing committee that meets once per month. The Medical Director Subcommittee members are a diversified group of medical practitioners who approve or deny any credentialing or policy recommendations made by the Credentialing Subcommittee. Any questions regarding activity conducted by the Medical Director Subcommittee can be directed to Senior Preferred HMO credentialing staff.

HOSPITAL BASED PRACTITIONERS – NOT CREDENTIALLED

Other hospital-based practitioners who will not be providing care in a clinic setting including, but not limited to: advance practice nurses (including certified registered nurse anesthetists); physician assistants - certified; physical therapists; and, certified anesthesiology assistants; moonlighting residents in urgent care; emergency room physicians and pathologists who are not subject to credentialing.

Senior Preferred HMO reserves the right to review practitioners including, but not limited to, those types named above and can decide at any time to bring a hospitalist or a short-term locum tenens practitioner's file to the Credentialing Subcommittee for a decision.

Other potential network practitioners must have a current license / certification and training appropriate to their scope of practice.

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7.8 PAYABLE PROVIDERS

It is a Senior Preferred HMO requirement that practitioners within the network complete the credentialing process and receive credentialing approval by the Medical Director Subcommittee, prior to payment of claims. Senior Preferred HMO reserves the right to withhold payment to practitioners that are not successfully. Payment of claims for services rendered to Senior Preferred HMO members prior to credentialing approval date will not be made except as required by law for urgent and emergent care, or at the discretion of Senior Preferred HMO on an exception basis.

7.8a Request for Exceptions

If extenuating circumstances exist, the practitioner / provider may request that Senior Preferred HMO make an exception and pay claims for a practitioner for services rendered prior to credentialing approval. The practitioner / provider must make their request to the Medical Director in writing. The request must include an explanation as to why an exception should be made, including any documentation to support the appeal. Any exceptions to the policy will not be granted for more than 60 days. In the event the practitioner / provider does not meet Senior Preferred HMO requirements within 60 days, Senior Preferred HMO will proceed to deny existing claims, and any denial of payment will become practitioner / provider liability. If claims are submitted to Senior Preferred HMO, they will be returned to the provider with an explanation that the practitioner / provider must resubmit the claim for payment when the practitioner / provider is credentialed and meets participation criteria.

7.8b Medicare and Medicaid Exclusions / Eligibility / Medicare Opt-Out

Practitioners who have Medicare / Medicaid sanction(s) and continue to treat members will be considered nonpayable. Practitioners with sanctions, limitations on licensure and / or other restrictions will be reviewed prior to the payment of claims.

Per CMS and the Office of Inspector General (OIG), Senior Preferred HMO will pay a practitioner / provider with a Medicare / Medicaid sanction for emergent or urgent services only, on a one-time-only basis. However, Senior Preferred HMO will not pay a sanctioned provider for emergency services if the provider is employed or contracted to routinely provide emergency services. In addition, if Senior Preferred HMO does pay for the services of a sanctioned provider, Senior Preferred HMO will notify the member that the provider was sanctioned and that Senior Preferred HMO will not pay if the member goes to that provider again.

Practitioners who have opted out of Medicare are non-payable for the two-year period that follows such decision. The only exception to that rule is for emergency and urgently needed services where a private contract has not been entered into with a beneficiary who receives such services. Senior Preferred HMO will pay for emergency or urgently

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needed services furnished by a practitioner to an enrollee in the Senior Preferred HMO plan who has not signed a private contract with a beneficiary, but will not otherwise pay for services provided by opt-out practitioners.

7.8c Behavioral Health Providers

To be considered a Senior Preferred Behavioral Health payable provider or an Alcohol and Other Drug Abuse (AODA) payable provider, the following conditions must be met –

Qualified Treatment Facility

Senior Preferred defines a qualified treatment facility as *a facility, institution, or clinic duly licensed and operating within the scope of its license* and includes programs approved under the following –

- Medically managed detoxification (DHS 75.06);
- Medically monitored residential detoxification (DHS 75.07);
- Medically managed inpatient treatment service (DHS 75.10);
- Medically monitored treatment (DHS 75.11); or
- A psychiatric unit including detoxification and psychiatric bed of an acute care general hospital.

Outpatient Services

Outpatient services means *nonresidential services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems provided for the purpose of enhancing the treatment* by any of the following –

1. A program in an outpatient treatment facility, if both the program and the facility are approved by the Wisconsin Department of Health Services (DHS), the program is established and maintained according to rules promulgated under s. 51.42(7)(b) and the facility is certified under s. 51.04.
2. A licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office.
3. A psychologist licensed under Ch. 455.
4. A licensed mental health professional — that is, a clinical social worker licensed under chapter 457, a marriage and family therapist who is licensed under §457.10, or a professional counselor who is licensed under §457.12 - practicing within the scope of his or her license under chapter 457 and applicable rules.

Senior Preferred requires the program to be certified under –

- Ambulatory detoxification service (DHS 75.08);
- Outpatient non-residential treatment service (DHS 75.13); or
- Individual, group or family psychotherapy provided in an outpatient setting.

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Services must be provided in a qualified professional office setting (i.e., outpatient hospital, clinic, professional office suite, etc.) Following is a list of facilities considered non-payable; including but not limited to: homes; schools; universities; centers; shops; club houses; jail; church; ranch; camp; and vehicle, etc.

Transitional treatment

Includes services or programs approved by DHS include –

- Adult, Child or Adolescent Day treatment programs (HRS 75.12);
- Residential treatment programs (HFS 75.14); or
- Partial hospitalization programs in a qualified treatment facility.

AODA counselors

If practicing in the state of Wisconsin, practitioner must be licensed by the State of Wisconsin as a Clinical Substance Abuse Counselor. If practicing in Iowa, practitioner must be certified by the Iowa Board of Substance Abuse Certification at the CADC or ACADC level, or if practicing in Minnesota, practitioner must be certified by the Minnesota Department of Health as a LADC. AODA counselors must work under the supervision of a licensed physician or licensed psychologist who meet the requirements of this policy.

Non-Wisconsin providers must meet the certifications and requirements set forth within their state and those noted above in this Section, where applicable.

7.9 TYPES OF REVIEW AND APPEAL PROCESSES

7.9a Overview

Peer Review Process

The Medical Director is responsible for the peer review activities performed by the subcommittee structure within Senior Preferred HMO as well as ad hoc utilization management peer review activities performed.

Physicians who perform peer review within Senior Preferred HMO are required to be credentialed practitioners within the network, unless expert peer review is determined to be required by the Medical Director Subcommittee. Peer Review is performed in accordance with established policies and procedures within Senior Preferred HMO.

All documents reviewed and all documentation developed and maintained in the peer review process is a product of “medical peer review” which provides protection, within the extent of the law, from discoverability.

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Professional Review Action and Appeal Process

To obtain more specific information regarding Practitioner / Provider Grievance and Appeal Processes, including the Credentialing and Professional Review action and appeal process, please reference Section 7.9b of this Provider Manual.

Disciplinary and Remedial Action Process

Senior Preferred HMO is committed to providing quality health care and services to its members. In order to ensure this, Senior Preferred HMO has policies and procedures for remedial and disciplinary actions. This process may involve the limitation, reduction, and / or termination of practitioner / provider privileges to participate in Senior Preferred HMO.

Member Grievance Process

Senior Preferred HMO has a structured process for the review of member complaints, grievances and appeals. This process meets all standards of licensure set forth by the state of Wisconsin and CMS.

7.9b Professional Review Action

Policy

Senior Preferred HMO is committed to effective peer review of its providers or practitioners to improve the quality of medical care provided to its members. In furtherance of that goal, Senior Preferred HMO has the responsibility to review any reports of information, which raise questions regarding the professional competence or conduct of any provider, or practitioner that affects or could affect the health and welfare of Senior Preferred HMO members.

Should the Medical Director, or Senior Preferred HMO conclude that information received warrants the initiation of a formal peer review process, the Senior Preferred HMO provider or practitioner, or those in the application process, shall be entitled to notice of a proposed action and hearing by a Hearing Committee. A Hearing Committee's recommendation for professional review action against a Senior Preferred HMO provider / practitioner shall be submitted for final decision.

The right to a hearing under this peer review process is strictly limited to cases in which professional review action is necessary to address quality of care, competence, or conduct, concerns that would affect care provided to patients by the Senior Preferred HMO providers or practitioners. The hearing process has no application to decisions by providers to terminate the employment of members of their professional staffs, or Senior Preferred HMO providers or practitioners for business reasons, including but not limited to, the elimination or reduction of staff positions or the non-renewal of existing contractual relationships. While there is no appeal process for eliminations, terminations or non-renewals based on lack of business need, the provider / practitioner may reapply after six months.

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Professional review action is an action or recommendation based on the professional competence or professional conduct of an individual that could adversely affect the health or welfare of a patient and may adversely affect the employment, membership or participation of the provider or practitioner in their current practice and / or Senior Preferred HMO. This term excludes actions that are primarily based on the following –

- Practitioner / provider association, or lack of association, with a professional society or association;
- Practitioner / provider's fees, advertising or engaging in other competitive acts intended to solicit or retain business;
- Practitioner / provider's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;
- Practitioner / provider's association, supervision, delegation of authority, support, training or participation in a private group practice with a member of a health care practitioner or professional; or
- Any other matter that does not relate to the professional competence or professional conduct of a provider and which does not and could not adversely affect the health and welfare of the patient.

Procedures

1. Professional Review Actions

A professional review action must be taken in the reasonable belief that this action is necessary. Professional Review Action means the activity is undertaken by Senior Preferred HMO to –

- Determine whether the practitioner or provider will be given participation in the Senior Preferred HMO network.
- Determine the scope and conditions of participation in Senior Preferred HMO.
- Change or modify such participation in Senior Preferred HMO.

Note: A fair hearing is not required where action is taken for reasons other than concerns about quality of care, clinical competence or professional conduct.

2. Recommendations for Proposed Actions

The right for a fair hearing will be afforded to a provider or practitioner regarding the following actions –

- An adverse credentialing decision or notification of a possible adverse credentialing decision;
- Suspension of participation in Senior Preferred HMO;
- Revocation or termination of participation in Senior Preferred HMO, for quality care concerns, competence issues, or conduct affecting patient care;

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- Conditioning of provider / practitioner participation in Senior Preferred HMO on probationary status; and,
- Conditioning imposed on provider / practitioner participation in Senior Preferred HMO, such as required supervision or continuing education.

3. When Deemed Adverse

A recommendation for proposed action, as defined in the Professional Review Action, shall be deemed to be adverse only when it has been taken by –

- Medical Director;
- The Credentialing Subcommittee;
- The Quality Improvement Subcommittee;
- Any subcommittee or ad hoc committee appointed by the aforementioned committees; and,
- An immediate suspension or restriction of Senior Preferred HMO participation subject to subsequent notice and a hearing where the failure to take such action may result in imminent danger to the health of an individual.

4. Notice of Proposed Adverse Action

Special notice of an adverse action shall promptly be given by the Medical Director, on behalf of the professional review body. The special notice shall provide the provider with the following information –

- That a professional review action has been proposed;
- The nature of the proposed action;
- The reason for the proposed action;
- Provider or practitioner right to request a hearing on the proposed action within 30 calendar days from receipt of notice;
- Notice that the right to a hearing shall be forfeited if there is failure without good cause to request a hearing within 30 calendar days, or failure to appear at a requested hearing and the consequences of such failures stated, to include the specific date upon which the proposed action would become final;
- Notice that any hearing shall be held before a Hearing Committee
- Notice that at the hearing there is the right to representation by an attorney, receipt of record of proceedings, call, examine and cross-examine witnesses, present evidence, submit written statement and receive written recommendation of any final decision.

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Request for Hearing

A grieving provider shall have 30 days to file a written request for a hearing, from the date of his / her receipt of special notice. Such request shall specify with particularity portions of the adverse recommendation or action that the provider / practitioner seeks to contest, and shall be deemed to have been made when delivered to the Manager, Provider Relations in person or when sent by Certified mail to –

Manager, Provider Relations
Senior Preferred
840 Carolina Street
Sauk City, WI 53583

5. Notice of Time and Place of Hearing

Upon receipt of a timely request for a hearing, the Medical Director shall be notified, and the Manager of Provider Relations shall coordinate and implement the hearing process which shall not be held less than 30 days from the date notice of hearing is given to practitioner. Senior Preferred HMO shall send notice to the provider / practitioner by Certified Mail, of the time, place, date of hearing and a list of witnesses expected to testify against the provider / practitioner as well as concise statement of the alleged acts or omissions, a list by number of specific or representative patient records in question, and / or the other reasons or subject matter forming the basis for the action.

6. Hearing Committee Report

Within seven days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Medical Director and the Manager of Provider Relations of Senior Preferred HMO or his / her designee.

7. Action on Hearing Committee

Within 15 days after receipt of the report of the hearing committee, the Medical Director Subcommittee or subcommittee, or in the case of a credentialing issue, the Credentialing Subcommittee, shall consider the same and affirm, modify or reverse its recommendation or action in the matter.

8. Exceptions to the Hearing Requirements

A hearing is not required when there is a suspension or restriction of scope of practice for not more than 14 days, during which time an investigation is made into the need to take a formal professional review action; or when there is immediate suspension or restriction of scope of practice under circumstances which Senior Preferred HMO, in good faith, believes to be emergent, where the failure to act may result in an imminent danger to the health and / or safety of a member; or when a practitioner terminates employment with a

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facility that has a Provider Services Agreement with Senior Preferred HMO; or when a practitioner's authority to provide a service to members is limited based on employment, reason of expiration or early termination of a Provider Services Agreement.

9. Reporting Requirements

Proposed Actions become final (and therefore, reportable within 15 days of the date of final action to NPDB and / or HIPDB) if –

- There is failure to request a hearing within the 30 day time limit, or
- There is failure to appear for a requested hearing without good cause, or
- The fair hearing process is completed, but the original Action is upheld.

A copy of each adverse action report submitted to NPDB and / or HIPDB must also be mailed to the appropriate state licensing board for its use.

Any questions regarding professional review, appeal request or appeal hearing can be directed to the Manager, Provider Relations, at (800) 394-5566.

7.9c Provider Grievance Resolution And Appeal Process

Senior Preferred HMO encourages feedback and input from all contracted practitioners and providers related to any medical, administrative, or Senior Preferred HMO matters.

Senior Preferred HMO has a process for dispute resolution for provider grievances and complaints. A grievance is a written dissatisfaction from a practitioner / provider regarding Senior Preferred HMO operations. A complaint is an oral dissatisfaction from a practitioner / provider.

If a practitioner / provider has a grievance, complaint or other problem regarding any aspect of the Senior Preferred HMO operations, the practitioner / provider should first contact the department of Provider Relations, or the Medical Director, to discuss the matter. Documentation of issues will be forwarded to individual practitioner / provider files.

- Senior Preferred HMO will use provider / practitioner complaints / grievances as a source of feedback to improve Senior Preferred HMO responsiveness to provider network and to improve operations.
- Examples of scope include delayed payment by Senior Preferred HMO, request for exception to policy, or consideration of change in process or procedure.
- In the event a provider would like to appeal a Senior Preferred HMO policy decision based on extenuating circumstances (i.e., request an exception be made to reconsider a claim payment denial); a provider must document in writing the extenuating circumstances, the corrective action taken to prevent a reoccurrence and the education / notification to staff. This letter should be addressed to: Manager, Provider Relations. The letter will be reviewed by the Provider Relations

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department and other departments as required in order to make determination. Senior Preferred HMO will respond to the provider / practitioner within 30 days after receipt of the appeal letter.

- If the matter cannot be resolved informally within a reasonable time to the practitioner / provider's satisfaction or not more than 60 days, the practitioner / provider may submit a written grievance to the Senior Preferred HMO Medical Director, and at the discretion of the Medical Directors, an ad hoc committee shall be appointed by the Medical Director to hear the grievance.

Written grievances should be mailed to –
Senior Preferred
Attention: Manager, Provider Relations
P.O. Box 610
Sauk City, Wi 53583

Or call Provider Relations at (800) 394-5566.

The ad-hoc committee responsibilities shall include –

- Hear the practitioner / provider personal testimony and review submitted documentation from both the practitioner / provider and Senior Preferred HMO. The personal presence of the practitioner / provider who requested the hearing shall be required. A provider who fails without good cause to appear and proceed, shall be deemed to have waived his / her rights.
- To recommend action if necessary to resolve grievance.
- To act as the final arbitrator in deciding the resolution of the grievance.

The ad hoc committee shall consider the matter as soon as practicable or within 30 days after its receipt of the grievance, conduct such investigation of the grievance as may be necessary, and recommend such correction action (if any) to the Medical Director and Executive Director within seven working days.

If it is deemed that no action is necessary, the Medical Director will send written notification to the practitioner / provider within seven working days. Copies of the decision will be placed in the respective practitioner / provider file. If corrective action is necessary, Executive Director and Medical Director shall take such action as it deems appropriate within 15 days upon receipt of the recommendation of the ad hoc committee. Their recommendation will be made known to the Director, Provider Network Management and he / she will ensure that the necessary documentation is placed in the practitioner / provider file. If the corrected action is deemed disciplinary in nature, the action will be addressed consistent with the Disciplinary Action Policy / Procedure referenced in Section 7.9d. The Medical Director will notify the practitioner / provider of the disposition of the grievance and any corrective action taken with respect to grievance.

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The decision of the Senior Preferred HMO Board Director and Medical Director shall be final and binding on both Senior Preferred HMO and the practitioner / provider.

Professional review actions against a Senior Preferred HMO practitioner / provider or applicant will be addressed as defined in Senior Preferred's policy 11.108 *Professional Review Action and Appeal Policy* or policy 11.215 *Denial of Potential Practitioners and Termination of Existing Network Practitioners*.

7.9d Disciplinary Action Policy / Procedure

Senior Preferred HMO will utilize the following guidelines in addressing and monitoring practitioners and providers regarding disciplinary actions.

It is the responsibility of the practitioner / provider to report all suspensions and termination of their licensure and / or certification to Senior Preferred HMO, Provider Relations department at (800) 394-5566. Senior Preferred HMO will comply with all necessary required regulations (state / federal) for licensure suspensions or termination as deemed by the state in which the practitioner / provider practices. The appropriate Senior Preferred HMO department will assist in transferring members to a new Senior Preferred HMO practitioner / provider, if necessary.

Any reduction, suspension or termination of privileges for greater than 30 days will be reported to the National Practitioner Data Bank and / or HIPDB, state and federal agencies as required by law.

Senior Preferred HMO has developed processes to identify and improve substandard quality of care issues in both administrative and clinical areas. One or more issues will constitute an infraction. Issues of non-compliance will be identified in writing by the appropriate Senior Preferred HMO committee and forwarded to the provider. It will be the provider's responsibility to submit a written Corrective Action Plan (CAP) to the appropriate committee of the Plan within 30 days of receipt of their notification. The CAP should include interventions to achieve and maintain improvements. Corrective action plans are reviewed by Senior Preferred HMO for appropriateness. Senior Preferred HMO reserves the right to require providers to submit or amend corrective action plan to the satisfaction of appropriate committee.

Senior Preferred HMO has developed a severity based rating system to assess and recommend disciplinary action as dictated by the issue identified.

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Severity Level I

Providers in this category would be identified as follows –

- Non-compliant with Senior Preferred’s policies and procedures, accreditation agency standards, or applicable state / federal law and regulations;
- Provide medically unnecessary care;
- Utilize health care resources inappropriately; and
- Demonstrate substandard judgment or quality of care without presenting a potential threat to the health or welfare of the membership.

Providers whose actions fall into this category are delivering acceptable clinical care and administrative services; however, opportunities for improvement are apparent. If these practitioners support and cooperate with the corrective action plan and maintain adequate improvement, no further action will be necessary. At recredentialing, the improvement(s) required, versus results obtained, will be evaluated with existing quality of care profile components as part of the determination from continued network participation.

Unsatisfactory resolution could advance the provider into Severity Level II.

Severity Level II

Providers in this category would be identified as follows –

- Demonstrate continued non-compliance with corrective action plan(s);
- Demonstrate a lack of professional conduct or other inappropriate actions and / or is found to be under investigation for such by the state licensing agency;
- Found to be under investigation by CMS or other agencies for fraud and / or abuse;
- Found to be in breach of contract provisions;
- Continued demonstration of substandard judgment in the delivery or quality of care that presents a potential threat to the health or welfare of the membership.

For participating providers whose actions fall into this category, suspension or termination of the provider may occur until further investigation is performed. This would include the right of an appeal. Results of the investigation will be reviewed by the Utilization Management Subcommittee, Credentialing Subcommittee or the Quality Improvement Subcommittee.

If the participating provider’s actions jeopardized the health and / or welfare of a member, immediate investigation and action is taken by the Medical Director or his / her designee including suspension from the network. If a participating provider is under investigation by a state or federal agency for willful misconduct, the Medical Director, or

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his / her designee, has the authority to take the appropriate action upon notification from a credible source.

At any point that a participating provider's privileges are revoked, suspended or terminated by a hospital or clinic, based on quality of care issues the Medical Director, or his / her designee, has the authority to suspend the provider's network participation until further investigation is conducted by the appropriate authorities.

At any time that a state or federal agency revokes, suspends or terminates a provider's license or privileges, the Medical Director, or his / her designee, has the authority to suspend the provider's network participation until further investigation is conducted by the appropriate authorities.

Procedure

Senior Preferred HMO shall offer the following procedures to providers, before such corrective action becomes final.

The four steps available to Senior Preferred HMO for providers are as follows –

1. STEP ONE — WARNING

- A warning will be issued to any provider for a minor breach of contract as outlined in Severity Level I. A warning will be issued in writing to the provider by the appropriate subcommittee. Such notice shall state the nature of the warning under consideration and suggestions for improvement. A CAP may be requested. The provider will be given the opportunity to respond to the warning in writing within 10 days after the receipt of such notice. Further possible actions will be applied if the situation is not rectified.

2. STEP TWO — PROBATION

- A probationary period, if appropriate, of up to three months will be imposed on providers for subsequent violations or previous violations which have not been satisfactorily corrected. Probation is considered a "watch" period and is not reportable to state / federal agencies. The provider will be notified of the probation in writing by the Medical Director or his / her designee.
- Such notice shall include the nature of the corrective action required. The provider at risk will be required to submit a written CAP within 30 business days or less (as documented by certified mail receipt).
- During the probationary period, the appropriate subcommittee will closely monitor the provider / practitioner in meeting the interventions outlined in the

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plan of correction. The Medical Director or designee will be responsible for monitoring compliance and reporting results to the appropriate subcommittee.

- The probationary period will be terminated by the Medical Director or his / her designee as evidenced by compliance with the plan of correction, or at the end of three months, whichever comes first, unless there is an exception made by the Medical Director. This decision will be communicated in writing to the provider / practitioner and Provider Relations within 10 working days. Provider Relations will notify Senior Preferred HMO management of the termination of the probationary period.

3. STEP THREE —SUSPENSION

Providers in this category will be identified as follows –

- Practicing under the influence of alcohol and / or other drug(s).
- Gross and flagrant violations of standards of professional practice.
- Repeated violations of administrative policies and / or procedures required within the utilization review and / or quality assurance programs.
- Violation of the Professional Code of Ethics as it applies to the provider's discipline.
- Failure to meet the established probationary standards as outlined above in Step II, unless an exception has been made.
- In the event that the provider does not meet the established probationary standards, a suspension may occur. Suspension may occur for a minimum of 30 days, but no longer than six months. The appropriate subcommittee will forward a recommendation to the Medical Director, or his / her designee, of either continued participation or termination from the network depending on the violation and the circumstances surrounding the situation. Providers will be notified of a suspension in writing by the Medical Director on behalf of the Medical Director Subcommittee within five working days. All written notification from the Medical Director or his / her designee will be by certified mail. Notice will afford practitioner appeal rights.

Based on the severity of the action, the Medical Director, or his / her designee, will maintain the right to make an immediate decision or form an ad hoc subcommittee of the Medical Director Subcommittee to evaluate recommendations and determine the final outcome. The ad hoc committee will be made up of designees representing the appropriate plan committees. The Medical Director Subcommittee shall consider this recommendation at its next regular meeting or within 30 days. In its deliberations, the Committee shall review all of the information and material considered by the Medical Director, his / her designee or the ad hoc subcommittee. Any additional information received from any other source will be considered at this time and reported to all appropriate subcommittees. Regulatory agencies will be advised accordingly.

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4. STEP FOUR — TERMINATION

Termination may occur at any time for breach of contract by either party or when any terms of the agreement or suspension cannot be resolved to the satisfaction of the appropriate committee and the practitioner / provider.

The appropriate subcommittee will have the right to recommend termination of participation in the network immediately under any of the following circumstances –

- The practitioner / provider, in the opinion of the appropriate subcommittee becomes unable, by reason of illness, incapacity or other cause, to perform a significant portion of his / her duties under the agreement.
- The practitioner / provider's licensure / certification is suspended, revoked, or voluntarily relinquished or subject to terms of probation or other restrictions determined by the appropriate credentialing / licensing body.
- The practitioner's clinical privileges at any facility are reduced, revoked, denied, or voluntarily relinquished based on quality of care issues.
- The practitioner / provider is convicted of a felony.
- The practitioner / provider is expelled or suspended from a federal insurance program.
- The practitioner's / provider's professional liability insurance coverage is no longer in effect.
- In the judgment of either party, if the other party is rendering care in manner that jeopardizes the health of any patient, damages the reputation of either party, or interferes with either party's mission as it relates to quality of care, competence, or conduct affecting patient care.

All actions taken by Senior Preferred HMO to suspend, revoke or terminate a contract with a provider / practitioner will afford the right of appeal if it has resulted from concerns about clinical competence, quality of care, or professional conduct.

7.10 STANDARDS OF CONDUCT

Senior Preferred maintains a Compliance Program to ensure compliance with all applicable federal and state laws and regulations. A copy of the Standards of Conduct will be provided to you upon request by contacting the Compliance department at (608) 881-8151. If you have a question as to whether or not a procedure or action conforms to the Standards of Conduct, you should contact the Senior Preferred Compliance Officer at (800) 362-3310.

Persons who become aware of violations of the Standards of Conduct are encouraged to report them to their supervisor. Alternatively, such concerns may be communicated to the Compliance Hotline: Local (608) 644-3495; toll-free (844) 492-2996. The hotline may also be accessed by e-mail at compliance.hotline@quartzbenefits.com.

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7.11 ACCESS STANDARDS

All Senior Preferred HMO participating providers and practitioners will ensure sufficient staffing and coverage of health care services to provide timely services for both new and established Senior Preferred HMO members. Senior Preferred HMO members have direct access to all participating Senior Preferred HMO practitioners or providers, including specialists. Female members have direct access to a participating Senior Preferred HMO women's health specialist for routine and preventive care services. Senior Preferred HMO has set standards for appointment access availability for members. All Senior Preferred HMO participating practitioners and providers are expected to comply with the standards described below.

SERVICE	ACCESS STANDARD*
Primary Care	Within two weeks of date of call for appointment
Specialist	Within four weeks of date of call for appointment
Behavioral Health – routine	Within 10 working days of call for appointment A member has telephone access to screenings and triage, if applicable; Members reach a non-recorded voice within 30 seconds and; Abandonment rates do not exceed 5 percent at any given time.
Urgent care	48 hours
Life-threatening emergency	Immediate

**All access standards are based on calendar days.*

The provider is expected to meet all appointment scheduling, wait time and office hours standards and are required to –

1. Follow appointment wait time standards
 - Wait times for scheduled appointments should not be 20 minutes beyond scheduled appointment time.
 - When care is unavoidably delayed, members must be notified of the delay and given the opportunity to reschedule their appointment. Attempts will be made to reschedule the appointment as medically appropriate and as close to the original date as possible.
2. Provide services 24 hours per day, seven days per week.
 - All providers should have an appropriate after-hours phone message available for patients calling in after normal business hours. We recommend provider's answering machines include their name and office hours and the name and phone number of a hospital or emergency services provider where a member can obtain after-hour care or emergency care.

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- Suggested language for providers to use in their voicemail systems –
“You have reached the [Name of Clinic]. Our office hours are [Office Hours]. If this is an emergency, please call 911 or contact the nearest hospital or emergency services provider. The nearest emergency services provider in our area is [Name of Hospital] at [Phone Number of Hospital].”
- 3. Have accessibility for handicapped members as defined by the Americans with Disabilities Act (ADA), the Civil Rights Act, and any state or federal requirements to meet special and cultural needs.
- 4. Ensure that interpreter services are available for members with language and hearing impairments.
- 5. Utilize Senior Preferred HMO network participating practitioners.
Ensure there is a process in place for communication between network providers.
- 6. Senior Preferred HMO must ensure that members have reasonable access to the care and services they require. Senior Preferred HMO has established geographic access standards –
 - 30 minutes or 30 miles to primary care and inpatient services;
 - 60 minutes or 60 miles to specialty care or behavioral health;
 - In rural areas, determination will be based on normal travel patterns for the Senior Preferred HMO service area.

Senior Preferred HMO will monitor and evaluate providers’ access and availability. The following evaluation methods will be used –

- Telephone survey conducted quarterly to 25 percent of the network;
- Site visits and routine Provider Relation staff visit feedback;
- Member satisfaction surveys;
- Compilation of member complaint data; and
- Provider feedback.

The provider is expected to meet all appointment scheduling, wait time and office hour standards. Practitioners and providers will be notified in writing of non-compliance with Senior Preferred HMO appointment access standards. Practitioners / providers will be given an appropriate period of time to correct any non-compliance issues and / or recruit additional practitioners.

7.12 MEDICAL RECORD DOCUMENTATION AUDIT

To ensure that Senior Preferred PCPs meet prescribed standards, a Medical Record Documentation Audit (MRDA) will be conducted biannually in primary care practice locations. Only clinics with paper medical records will be audited. For each clinic site audited, either 20 percent or 50 medical records (whichever is less) will be reviewed. A minimum of 10 medical records will be audited. For clinic sites where there are less than 10 records, 100 percent of available records will be audited. Medical records will be selected at random, based upon medical records pulled for HEDIS® data abstraction. The

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look back period for the medical record audit will be no more than 24 months. The goals of the audit include the following –

1. To ensure that a comprehensive medical record is maintained
2. To improve quality and decrease risk through provision of documented continuity between all practitioners involved in a member's care and services
3. To identify opportunities for improving continuous, effective and efficient health care and services to our members
4. To ensure patient confidentiality is maintained through secure storage and access of medical records
5. To ensure medical records are stored in a manner that allows easy retrieval

If your primary care practice uses paper records, notification will be given at least 72 hours prior to the scheduled visit. In addition, following completion of the audit, a written report indicating the MRDA results will be generated to the clinic facilitator within 14 business days.

7.13 NOTIFICATION OF PRACTITIONER / PROVIDER CHANGES

In the event of any practitioner or provider additions / deletions / changes, please complete the *Provider / Practitioner Notification Form*, found in the appendix of this Provider Manual.

If you are adding a practitioner we will review your request consistent with our contracting policy. If a decision is made to add the practitioner, a credentialing application form will be mailed to you under separate cover. Please remember that practitioners are not payable by Senior Preferred HMO until the credentialing process is completed and approval has been granted.

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SECTION 8: MEDICAL MANAGEMENT SERVICES

8.1 Medical Management Services

8.1a Overview of Utilization Management

8.2 Admission Notification

8.3 Elective (NonEmergent or NonUrgently Needed) Admissions Out-of-Network

8.4 Concurrent Hospital Review

8.5 Discharge Planning

8.6 Retrospective Review

8.7 Utilization Case Management

8.8 Utilization Review Criteria

8.9 Referrals and Authorizations

8.9a Referral Authorization Process

8.9b Prior Authorization

8.1 MEDICAL MANAGEMENT SERVICES

The Medical Management department performs utilization management and case management services under the direction of the Medical Directors. It is the expectation that Senior Preferred HMO practitioners / providers review, cooperate, and participate with the Medical Management requirements outlined below.

8.1a Overview of Utilization Management

Utilization Management performs the following services –

- Admission Notifications
- Elective Admissions Out-of-Network
- Concurrent Hospital Review
- Discharge Planning
- Retrospective Review
- Case Management
- Utilization Review
- Referrals
- Prior Authorizations

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8.2 ADMISSION NOTIFICATION

- Prior Authorization is required for all hospital admissions. Providers should contact a Senior Preferred Customer Service representative at (800) 394-5566.
- Questions related to coverage or benefits should be directed to a Senior Preferred Customer Service representative at (800) 394-5566.
- An Advanced Written Notice of Hospital Discharge Appeal Rights (The Important Message from Medicare) (OMB #0938) (CMS-R-193) will be issued to Senior Preferred HMO hospital inpatients. The hospital must deliver this notice at or shortly after admission, but no later than two calendar days following the member's admission to the hospital.

8.3 ELECTIVE (NONEMERGENT OR NONURGENTLY NEEDED) ADMISSIONS OUT-OF-NETWORK

All elective (nonemergency or non-urgently needed) hospital admissions out of the Senior Preferred HMO network require Prior Authorization before hospital admission to ensure that inpatient criteria have been met. This allows for identification of potential utilization or coverage issues and suggestions of alternative treatment settings, if appropriate.

Questions regarding admission or Prior Authorization through a written referral can be directed to the Medical Management department staff at (800) 394-5566.

8.4 CONCURRENT HOSPITAL REVIEW

- Concurrent hospital review is performed for inpatient hospital admissions.
- Concurrent review will consist of written documentation of pertinent information regarding how the member is meeting medical necessity. Milliman Care Guidelines will be used as a guide.

Inquiries regarding inpatient hospitalizations should be directed to Medical Management at (800) 394-5566.

8.5 DISCHARGE PLANNING

Discharge planning involves the assessment of a patient's need for medically appropriate treatment after hospitalization. Hospital staff and the attending physician will work with Medical Management by monitoring and assisting in this process.

1. Working in coordination with hospital staff, the attending physician, the member and / or family / caregivers, Senior Preferred Utilization Management (UM) / Case Management staff are able to identify those cases with chronic conditions for which alternative treatment settings might be available within the community.

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2. Senior Preferred HMO UM / Case Management staff will review the member's treatment plan with hospital staff in order to establish the post discharge treatment plan.
3. Senior Preferred HMO UM / Case Management staff will monitor all post discharge services for patient progress and prognosis.
4. Questions or concerns regarding the discharge planning process should be directed to the Medical Management department at (800) 394-5566.
5. Questions or concerns regarding benefit issues should be directed to a Senior Preferred Customer Service representative at (800) 394-5566.

8.6 RETROSPECTIVE REVIEW

Utilization information is collected on a retrospective basis through chart review, peer review and claims review. Retrospective review is used to assess specific services or patterns of care for appropriateness, underutilization, over utilization, efficiency and outcomes.

8.7 UTILIZATION CASE MANAGEMENT

The Medical Management department Case Manager manages member's health care benefit to ensure the best quality of care and optimizing insurance benefits. The Case Manager is responsible for the following –

- Identifying appropriate alternatives to hospitalization yet achieving cost-effective quality of care.
- Discharge planning of hospitalized patients begins upon receipt of information of the impending admission or upon the initial review of the patient's hospital record.
- The acquisition of needed medical supplies and equipment, as well as home health services (skilled nursing care, physical therapy, speech therapy and occupational therapy), is directed through contracted providers (whenever possible) and negotiates discounts with non-contracted providers.
- Coordinating with reinsurance carrier care manager when applicable.
- Manages Prior Authorization requests for medical appropriateness and benefit applicability. Requests may include but are not limited to surgical procedures, diagnostic testing and durable medical equipment.
- Manages concurrent reviews of admissions in and out of network, referrals to out of network facilities for Mental Health / AODA, transitional care, and other medical and surgical procedures. Works directly with discharge planners to facilitate transfers to lesser level of care as appropriate.
- Manages Prior Authorization and continued stay review of home health treatment plans, skilled nursing facility (SNF) stays, and hospice in accordance with Senior Preferred policy.

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- Upon initiation of home health services ordered by the attending practitioner, the Case Manager will maintain communication with the home health nurse. The Case Manager will coordinate care with the home health agency as needed until the patient is discharged from care and resumes care from the attending practitioner.
- Identification and reporting of quality of care issues to Medical Director.

8.8 UTILIZATION REVIEW CRITERIA

Senior Preferred HMO will follow Medicare's national coverage decisions as well as specific written medical review determinations of the local Medicare carrier. Determinations of medical necessity and appropriateness may be based upon the following additional sets of criteria –

- Milliman Care Guidelines.
- Senior Preferred Medical Policy and Procedure Manual.
- CMS Local Coverage Decisions and National Coverage Decisions
- American Society of Addiction Medicine (ASAM)
- Criteria are reviewed periodically to ensure consistency with current community standards.
- As new criteria or updates to criteria are proposed, changes are communicated to applicable Senior Preferred HMO practitioners / providers for feedback.
- Approval is required by the Utilization Management Subcommittee and Medical Director Subcommittee prior to adoption of changes or additions to criteria.
- Utilization review criteria is available upon request
- Questions regarding criteria should be directed to Medical Management at (800) 394-5566.

8.9 REFERRALS AND AUTHORIZATION

8.9a Referral Authorization Process

All Senior Preferred HMO members will have direct access to Senior Preferred HMO participating practitioners and providers, including specialists. Referrals are not required between Senior Preferred HMO participating practitioners / providers. It is expected that the Primary Care Physician will be identified before or at the time of member appointment, and communication will occur between Senior Preferred HMO practitioners / providers in an effort to provide coordinated quality, cost effective care for all Senior Preferred HMO members.

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For services not available within the Senior Preferred HMO participating provider network our network of contracted specialty referral providers will be utilized whenever possible.

- To request prior approval, a Referral Authorization form must be generated by a Senior Preferred practitioner / provider.
- Referral requests including supporting medical record documentation may be sent in one of the following ways –
 - Faxed to the Medical Management department at (608) 881-8397
 - Mailed to Senior Preferred, Medical Management Department, 840 Carolina Street, Sauk City, WI 53583
- Referral Authorization forms (#51385) can be obtained online at SeniorPreferred.org/for-providers or by contacting the Medical Management department (608) 881-8738.
- The practitioner / provider may initiate the request while the patient is present to facilitate collection of insurance information.
- Requests must include the patient name, address, member ID number, phone number of the physician, number of visits and the specific services that will be provided outside of the Senior Preferred provider network.
- Information submitted will be reviewed by a Medical Director or appropriate Medical Management staff.
- If requested services can be provided within the Senior Preferred provider network, an explanation for out-of-network referring is necessary.
- Failure to obtain an approved referral authorization prior to services rendered may result in a denial of coverage.
- Initial determinations / decisions will be made within 14 calendar days of receiving the request (this may be extended up to 14 days if the plan determines it is necessary to obtain all supporting documentation).
- Medical Management will communicate the approval/denial of the request along with any limitation(s) to the following –
 - Member
 - Member file
 - Referring practitioner / provider
 - Physician / Facility referred to (approvals only)

Referrals will be denied for the following reasons –

- Services that can be provided within the Senior Preferred network
- Services to the provider based solely on patient request
- Non-emergent backdated requests from the member
- Appeal information is included in the communication of denials to the member, along with specific reasons for the denial and options available from Senior Preferred to practitioners / providers.

Our Medical Directors are available to discuss these decisions upon request by calling (800) 394-5566.

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- Services that are not urgent or emergent and do not require Prior Authorization include –
 - Services received from a non- participating Senior Preferred HMO provider when such services are follow-up care for stabilization after a medical emergency or urgent care condition.
 - Renal dialysis services received from non-participating Senior Preferred HMO providers out of the service areas.

8.9b Prior Authorization

Participating providers have the sole responsibility for making decisions regarding care. However, in order to monitor the frequency, intensity, and appropriateness of services rendered, Prior Authorization for certain services are required **before services are rendered**. The Prior Authorization process determines both benefit application and medical necessity.

Providers are required to assist Senior Preferred HMO members in obtaining Prior Authorization. Failure to obtain necessary Prior Authorization may result in a denial of services. Changes are periodically made to the Prior Authorization list; therefore, it is recommended that providers contact Customer Service at (800) 394-5566 to obtain the most updated information.

Prior Authorization Process

- Prior Authorization requests including supporting medical record documentation may be sent in one of the following ways –
 - Faxed to the Medical Management department at (608) 881-8397
 - Senior Preferred, Medical Management department, 840 Carolina Street, Sauk City, WI 53583
- Prior Authorization forms can be obtained online at SeniorPreferred.org/for-providers or by contacting the Medical Management department, (608) 881-8738.
- Information submitted will be reviewed by a Medical Director or appropriate Medical Management staff.
- Initial determinations / decisions will be made within 14 calendar days of receiving the request (this may be extended up to 14 days if the plan determines it is necessary to obtain all supporting documentation).
- Determinations will be communicated to the provider(s) and the member.
- Written confirmation to the provider and member will follow for all adverse determination decisions.

Our Medical Directors are available upon request to discuss these decisions by calling (800) 394-5566.

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The Senior Preferred Provider Directory is available at SeniorPreferred.org/for-providers.

Questions or concerns regarding access or availability of Senior Preferred HMO practitioners or providers should be directed to Provider Relations at (800) 394-5566 or at (608) 881-8231.

NOTE: Additions or deletions of procedures requiring Prior Authorization will be communicated to Senior Preferred practitioners / providers 60 days prior to their implementation date.

Supplier Instructions for Wheelchair Rentals and Purchases

Senior Preferred has a defined process for obtaining authorizations for wheelchair rentals and purchases. Detailed instructions can be viewed on Senior Preferred's website at SeniorPreferred.org/for-providers.

Wheelchair Purchases

To comply with federal regulations of consistency when applying benefits for all members, a Functional Mobility Assessment is required for all wheelchair purchases along with a physician's order. Upon written order for purchase of a wheelchair, the patient should be directed to a physical or occupational therapist for the assessment. A Functional Mobility Assessment form must be completed. The assessment will enable Senior Preferred HMO to ensure that the most appropriate equipment is being requested to meet the member's current medical needs. A copy of the Functional Mobility Assessment Form can be obtained from Senior Preferred's website at health care SeniorPreferred.org/for-providers.

SECTION 9: QUALITY MANAGEMENT AND POPULATION HEALTH

- 9.1 Overview of Quality Management and Population Health
- 9.2 Confidentiality
- 9.3 Conflict of Interest
- 9.4 Authority
- 9.5 Quality Measurement and Evaluation (HEDIS® and CAHPS®)
- 9.6 Practice Guidelines
- 9.7 Disease and Complex Case Management
- 9.8 Adverse Events
- 9.9 Quality Improvement Work Plan
- 9.10 Quality Improvement Evaluation

9.1 OVERVIEW OF QUALITY MANAGEMENT AND POPULATION HEALTH

Senior Preferred is committed to the ongoing improvement and evaluation of the quality and safety of medical and behavioral health care services provided to members. Senior Preferred credentials a comprehensive practitioner network that delivers high-quality, cost-effective care. Quality Management and Population Health is designed to facilitate this commitment.

Senior Preferred follows these guiding principles –

- Seek to maximize the quality of care and services received by members.
- Elicit involvement, input and support from our practitioner network.
- Recognizes and values preventive health care and health maintenance.
- Communicate our efforts to members and actively seeks feedback for improving care and services.
- Monitors and evaluates the services and care provided to members.
- A commitment to providing superior service, without discrimination, to all members including those who have special needs and those who are at high risk of developing special needs.
- Strive to serve a culturally and linguistically diverse membership efficiently and without discrimination.

Quality Management and Population Health is designed to objectively, systematically and continuously monitor, evaluate and improve the delivery of health care and related services provided to members.

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The program goals are to –

- Provide high quality, accessible, cost-effective health care, and identify opportunities for improvement in the areas of clinical and behavioral health practice, service and safety.
- Establish outcome measures to monitor the quality of care members receive. Participate in annual HEDIS® (Health care Effectiveness Data and Information Set) data collection and reporting.
- Elicit and support practitioner participation in quality improvement activities and to collaborate with provider organizations to enhance and assist with quality improvement programs.
- Assess member satisfaction with Senior Preferred through the CAHPS® (Consumer Assessment of Health Care Providers and Systems) Survey. (CAHPS® is a registered trademark of the Agency for Health Care Research and Quality.)
- Monitor access and availability of practitioner services in collaboration with the Provider Relations department.
- Monitor adverse events.
- Promote preventive services and wellness initiatives.
- Identify chronic medical conditions relevant to members and implement disease management (DM) and complex case management (CCM) programs for the purpose of monitoring recommended services, supporting self-management skills and providing disease-specific education.
- Identify opportunities for improvement in the areas of clinical and behavioral health practice, service and safety.
- Develop or adopt evidence-based clinical practice and preventive care guidelines in collaboration with participating practitioners. Disseminate the guidelines and monitor whether members receive care consistent with the guidelines.
- Identify quality concerns through evaluation of member grievances, complaints and appeals.
- Ensure confidentiality of patient information and medical records.
- Ensure best practices for medical record documentation.
- Be compliant with all quality improvement activities required by CMS, the Department of Health Services (DHS) and state regulatory agencies.
- Implement and maintain a quality program that qualifies for a National Committee for Quality Assurance (NCQA) rating of “Excellent”.
- Monitor and facilitate continuity and coordination of care between medical and behavioral health care practitioners and providers, and between primary care providers and specialists.
- Continually evaluate the effectiveness of these programs.
- Provide superior service without discrimination to all of members, including those who have special needs and those who are at high risk of developing special needs.

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- Serve a culturally and linguistically diverse membership by performing one or more of the following –
 - Analyzing existence of significant health care disparities in clinical areas
 - Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved
 - Conducting patient-focused interventions with culturally competent outreach materials that focus on race / ethnicity / language specific risks
 - Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs
 - Identifying and reducing a specific health care disparity
 - Providing information, training, and tools to staff and practitioners to support culturally competent communication

Providers will cooperate with the Senior Preferred's Quality Improvement activities to improve the quality of care and services and member experience. This includes the collection of performance measurement data and participation in the organizations clinical and services measure QI programs. Senior Preferred may use provider performance data for quality improvement activities. Practitioner performance data may be used for public reporting to consumers as required by NCQA.

9.2 CONFIDENTIALITY

- The provider, along with Senior Preferred staff, committee members and business associates agree to safeguard all individually identifiable health information, and to protect the confidentiality and integrity of all health care information exchanged between the provider and Senior Preferred. Both provider and Senior Preferred agree to comply with all applicable requirements of state and federal laws regarding health information, including, but not limited to the HIPAA administrative simplification laws concerning privacy, security and electronic transactions, and Health Information Technology for Economic and Clinical Health Act (HITECH);).
- Senior Preferred committee discussions are considered confidential. No clinical information will be disclosed outside of Senior Preferred without the expressed consent of the member or their designated representative.
- The breach of a member's confidentiality by an employee of Senior Preferred or a committee member constitutes grounds for disciplinary action, up to and including termination of employment.
- All information reviewed by the QM staff and committee structure is protected by the Federal Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.) and Wisconsin Statutes §146.37 and §610.70 to ensure the confidentiality of this information.
- All member and provider information (written, oral or electronic) is considered confidential, except where disclosure is mandated by law or regulatory requirement.

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- The Notice of Privacy Practices describes how Senior Preferred uses and discloses medical information, member rights (the right to inspect and copy, request amendment, accounting of disclosures, request confidential communications and request restrictions to disclosures); how to file a complaint; and who to contact at Senior Preferred regarding privacy issues.

You may obtain a copy of the Notice of Privacy Practices –

- On the Senior Preferred website at SeniorPreferred.org/for-providers
- By calling the Senior Preferred Privacy Specialist at (608) 881-8250.
- By writing to Senior Preferred at:
Attn.: Privacy Coordinator
840 Carolina Street
Sauk City, WI 53583

9.3 CONFLICT OF INTEREST

To ensure that quality issues are reviewed without bias and that actions are in the best interests of members, Senior Preferred mandates the following policies –

- All committee members are required to sign the Conflict of Interest Attestation prior to participation on a committee.
- To avoid actual or perceived conflicts of interest, Senior Preferred requires all committee members to provide appropriate disclosure. Any committee member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such member about the recommendation in question, which might reasonably be construed as adverse to Senior Preferred interests. This includes, but is not limited to, situations in which a committee member has a personal, financial or substantial interest in any recommendation of the committee.
- If the committee determines that a conflict of interest exists, it shall require the disclosing member to excuse him or herself from voting on the issue at hand.

9.4 AUTHORITY

The Board of Directors has ultimate responsibility for the QM program at Senior Preferred, supporting the program through provision of financial resources and staff for each operational area. The Board of Directors designates oversight of the QM program to the Medical Director Subcommittee. The Medical Director Subcommittee designates oversight of quality improvement activities to the Quality Improvement Subcommittee (QIS). Daily oversight of quality improvement activities is the responsibility of the designated associate medical director and director of clinical services. Issues and concerns pertaining to quality of care or services are presented to the QIS for review, analysis and

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recommended action. To ensure compliance with the continuous quality improvement process, the Board of Directors reviews report summaries of all quality improvement activities on a quarterly basis.

9.5 QUALITY MEASUREMENT AND EVALUATION (HEDIS® AND CAHPS®)

All data collected for the purposes of quality improvement activities is confidential information and is treated as such in accordance with the confidentiality policy.

- **Healthcare Effectiveness Data and Information Set (HEDIS®).** Data is collected annually per NCQA® HEDIS Technical Specifications. Data is collected from Senior Preferred claims data, available electronic medical record data, from providers by mail or fax or via on-site review of medical records. The Senior Preferred QM and Information Systems departments are responsible for the coordination of HEDIS. Some HEDIS measures require medical record review to provide accurate reporting of performance levels. For this reason, Senior Preferred staff may request to review medical records at the provider site or request providers to perform medical record review. If needed, Senior Preferred QM staff will provide training and data collection tools to assist the provider staff designated to perform these review.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®).** A standardized survey performed annually by an NCQA-certified vendor according to the HEDIS survey protocol. It is designed to capture consumer and patient perspectives on health care quality.

Aggregate HEDIS and CAHPS results are reviewed by the QIS, QM staff and other Senior Preferred departments. The QIS is provided with quality improvement activity reports from various health plan departments, and engages in discussions regarding identified improvement opportunities. Results are also reported to the Medical Director Subcommittee and the Senior Preferred Board of Directors. Measured results are also shared with providers via electronic communication and / or by provider mailings. A summary of the most recent results are available on our website at SeniorPreferred.org/for-providers. If you would like a more detailed report, please contact the QM department.

The following are examples of additional sources of data used to monitor quality –

- Medicare Health Outcomes Survey Results
- Medical Record Reviews (Inpatient, SNF, Hospice, Home Health)
- Utilization Data
- Quality Indicator Analysis
- Clinical Guideline Performance Studies
- Claims Data Reviews
- Member Satisfaction Surveys
- Provider Satisfaction Surveys
- Member Complaints and Grievances
- Preventive Care Services Utilization

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- Health Risk Assessment and Screening Monitors
- Medicare Health Outcomes Survey
- Peer Case Reviews
- Focused Reviews
- Pharmacy Utilization Data
- Possible Avoidable Hospital Days Review

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

9.6 PRACTICE GUIDELINES

To assist in the promotion of evidence-based care, Senior Preferred has adopted or developed and disseminates the following clinical practice guidelines for provider use –

- Child and Adolescent Preventive Care Guidelines
- Key Components in Managing Asthma
- Key Components in Managing ADHD in Primary Care
- Key Components in Managing Depression in Primary Care
- Key Components in Managing Diabetes
- Key Components in Managing Systolic Heart Failure

All guidelines are available on our website at SeniorPreferred.org/for-providers.

9.7 DISEASE AND COMPLEX CASE MANAGEMENT

Disease Management is a system of coordinated health care interventions and communications for populations with chronic conditions where self-management skills are paramount.

Senior Preferred utilizes programs to manage the health status of members with high-risk conditions and chronic diseases. The overall goal is to assist members in maximizing health and well-being. Enrollment is voluntary. DM programs include –

- **Asthma.** Qualifying members age 5 and older are enrolled in the asthma registry. Members are stratified according to risk – low and moderate. Interventions are based upon stratification and include a series of educational mailings and newsletters. Outcome measures are derived from the clinical practice guideline for the management of asthma, as well as HEDIS.

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- **Diabetes.** Qualifying members diagnosed with either Type 1 or Type 2 diabetes are enrolled in the diabetes registry. Members are stratified according to risk – low, moderate and high. Interventions are based upon stratification, and include a series of educational mailings and newsletters and / or telephonic interventions. Outcome measures are derived from the clinical practice guideline for the management of diabetes, as well as HEDIS.
- **Heart Failure.** Qualifying members diagnosed with heart failure are enrolled into the heart failure registry. Members are stratified according to risk – low, moderate and high. Interventions are based upon stratification and include a series of educational mailings and newsletters and / or telephonic interventions. Outcome measures are derived from the clinical practice guideline for the management of heart failure, as well as HEDIS®.

Senior Preferred also uses HEDIS Behavioral Health measures as its framework for monitoring member needs. Behavioral Health practitioners participate in the development of quality improvement initiatives and participate in decision-making on both the Behavioral Health Quality Subcommittee and QIS. Depression management in primary care remains a focus. Assessing continuity and coordination between medical and behavioral health care is done annually to ensure that exchange of information occurs between practitioners and that coexisting conditions are managed appropriately. Senior Preferred offers a **Complex Case Management (CCM)** program to members experiencing complicated and / or chronic health conditions that are high-cost, high-volume or high-risk. These are typically diagnoses that require the extensive use of health care resources. The CCM program is coordinated by a registered nurse who assists members to navigate the health care system. CCM is a benefit provided at no cost. The program utilizes provider referrals, claims / billing data along with member self-referrals to identify members. All eligible members are offered the program and participation is voluntary.

The goal of CCM is to help members regain optimum health and improved functional capacity, in the most appropriate setting and in a cost-effective manner. It involves a comprehensive assessment of a member's condition; a determination of available health plan benefits and resources; and development of a case management plan including performance goals, monitoring and follow-up.

Senior Preferred evaluates program satisfaction with CCM through an annual survey and reports effectiveness of the program using identified measures. If you identify a Senior Preferred member or caregiver that could benefit from disease or CCM support, please contact the QM department.

9.8 ADVERSE EVENTS

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Contracted providers must comply with all CMS guidance regarding coding, claims submission and reimbursement rules. Medicare participating providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the “Never Event” has not been reported, the health plan will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NCF) and adopted by CMS as a Serious Reportable Adverse Event. If you fail to comply with these requirements, the claim(s) will be denied as provider responsibility and the member cannot be billed for the charges.

Senior Preferred follows the CMS guidelines regarding Adverse Events as outlined in MLN Matters #6405 and #6634.

Senior Preferred will not cover a surgical procedure or other invasive procedure when the practitioner mistakenly performs: 1) the wrong procedure, 2) the correct procedure but on the wrong body part, or 3) the correct procedure, but on the wrong patient.

In addition, Senior Preferred will not cover hospitalizations and other services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the Adverse Event occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. However, related services do not include performance of the correct procedure.

Services must be billed appropriately when the following preventable Adverse Events occur: wrong procedure; the correct procedure but on the wrong body part; or the correct procedure but on the wrong patient.

- **Adverse Event outpatient claims:** must be billed with the surgical procedure code and modifier that indicates the type of Adverse Event: modifier PA (wrong body part), PB (wrong patient) or PC (wrong surgery) AND / OR diagnosis code E876.5 (wrong surgery), E876.6 (wrong patient) or E876.7 (wrong body part) must be present as one of the diagnoses codes on the claim.
- **Adverse Event inpatient claims:** must be billed with a type of bill 110. If there are covered services or procedures provided during the same stay as the Adverse Event service, then the facility must submit two claims; one claim with covered services unrelated to the Adverse Event and the other claim for any and all services related to the Adverse Event.
***Senior Preferred members shall not be responsible for payment, and must not be billed, for any service related to an Adverse Event.**

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Senior Preferred is obligated to disclose to CMS and other regulatory agencies, quality and performance indicators for benefits under the Plan regarding disenrollment, member satisfaction and health outcomes. Providers may be asked to assist Senior Preferred staff in meeting these requirements.

In addition to sanctions and complaints, Senior Preferred will perform semi-annual reviews on Adverse Events found through claims data as required by NCQA. For any questions regarding this update, please contact Customer Service at (800) 394-5566.

9.9 QUALITY IMPROVEMENT WORK PLAN

Annually, the QM department, the QIS, and the QM Medical Director develop a QM Work plan, which addresses: quality and safety of clinical care; quality of service; program scope; objectives; planned activities; time frames for activity completion; activity leader; ongoing monitoring and evaluation. The work plan is reviewed, evaluated and updated on an ongoing basis. It is presented to the Medical Director Subcommittee and Board of Directors for final approval.

9.10 QUALITY MANAGEMENT AND POPULATION HEALTH EVALUATION

The QIS evaluates the Quality Management and Population Health program and work plan on an annual basis. This review includes compliance with CMS standards and OCI requirements and overall effectiveness of the program. Based upon this review, recommendation for changes in the program plan, as well as improvement activities for the subsequent year, are presented to the Medical Director Subcommittee and the Board of Directors for approval.

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SECTION 10: PROVIDER BILLING AND REPORTING

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10.1 PAYMENT ISSUES

10.1a Conscience Waiver Protection

Senior Preferred HMO does not object to the provision of any service based on moral or religious grounds. Any such objection would be communicated to CMS, to current

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members and to prospective enrollees within 90 days of adopting such policy and prior to implementing the policy.

Providers who have objections to providing care or to carrying out a member's Advance Directive must notify Senior Preferred HMO of such objection.

10.1b Federal Funds

Payments received from Senior Preferred to provide services to Senior Preferred members are, in whole or part, from federal funds. Therefore, providers and their subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act and the Medicare Modernization Act of 2003.

10.1c Medicare Risk Adjustment

Risk Adjustment is the payment model that CMS uses for contracted Medicare Part C plans. The Risk Adjustment model places emphasis on the health status of the patient.

As a Medicare Part C plan, Senior Preferred HMO is required to submit claim data to CMS on a routine basis. That data is used by CMS prospectively and data collected in the current year, is used to predict the CMS payment to Senior Preferred HMO for the following year. CMS uses the diagnosis codes submitted for each individual patient in their formula to determine the payment.

Risk Adjustment data is collected from claims submitted, including hospital inpatient stays, hospital outpatient services and physician encounters. Demographic variables are also components of risk adjustment payment calculation (e.g., patient age, gender, Medicaid eligibility, disabled status, reason for original entitlement to Medicare, community based or long-term based.)

The payment is then risk adjusted according to the health status of the patient. Risk Adjustment factors are based on assignment to disease groups, also known as Hierarchical Condition Categories (HCCs). HCCs are determined by the diagnosis code submitted on the claim by the provider.

The level of Medicare payment is directly linked to diagnosis. It is imperative that providers document and submit all diagnosis codes at the highest level of specificity and that each diagnosis is documented in the medical record. Medical records must be signed and dated pursuant to CMS requirements.

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10.2 BILLING / CLAIM SUBMISSION REQUIREMENTS

Claims should be submitted electronically, consistent with the requirements set forth in 45 CFR Parts 160 and 162, (the HIPAA requirements for standard transactions using ASC X12 version 5010), or on paper, using industry standard CMS forms. Claims must be submitted utilizing valid and current HCPCS Level I (Current Procedural Terminology (CPT)), HCPCS Level II (National HCPCS), and / or revenue codes. Submission of Level I and Level II HCPCS modifiers are also required based on provider specialty (i.e., CRNA, Assistant Surgeon) and payment policy requirements (i.e., multiple surgery) for claim adjudication and accurate reimbursement. ICD·10·CM codes must be submitted at the highest level of specificity. Incomplete claims will be returned with a letter explaining the reason for returning the claim. All returned claims must be resubmitted with the necessary information for adjudication. Claims received with incorrect coding will be returned or denied. Providers should bill based on the services provided consistent with standard billing guidelines unless otherwise communicated by Senior Preferred HMO. Claims will be remitted electronically using Payment/Advice (835) or by paper Explanation of Payment. The Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC), as indicated, will be included to support the reason for denial. No Appeal rights are afforded for missing, invalid or incomplete denials or returned claims.

As a Medicare Advantage plan, Senior Preferred provides data to CMS, NCQA and HEDIS; this data is extracted from the services reported by providers.

In order to continue to meet quality measures, it is necessary for Critical Access Hospitals to report the HCPCS code along with the Revenue Code on all outpatient facility claims. This is not usually a billing requirement on claims submitted to traditional Medicare, however reporting the Revenue Code and the corresponding HCPCS code based on the Outpatient Prospective Payment System reporting requirements will assist us to continue our excellent ratings with these regulatory agencies.

Contracted providers are required to submit claims on behalf of Senior Preferred members and refrain from billing members until claims have been adjudicated by Senior Preferred. Providers must not bill members for services that are denied due to contractual limitations as indicated in the Payment / Advice (835) or Explanation of Payment.

Claims Submission Address –

Senior Preferred
Claims
P.O. Box 610
Sauk City, WI 53583

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10.2a Billing Reduced Services Modifiers

Providers submitting claims with reduction modifiers, including but not limited to modifiers 51, 52, 53, 63, 73, 80, 81, 82, and AS must submit full charges. Payment will be reduced appropriately upon receipt of the claim. Providers that are unable to submit full fees must notify the Provider Relations department prior to claim submission at (608) 881-8231 or (800) 897-1923, ext. 308231.

10.2b Timely Payment

Senior Preferred HMO will reimburse providers within 30 days of receipt of a clean claim. A "clean claim" has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made. Claims that require additional information or are subject to coordination of benefits will be adjudicated promptly upon receipt of requested information.

10.2c Coordination of Benefits Claims Filing Limit

Coordination of Benefits claims should be submitted as soon as possible, but no later than six months from the date of receipt of the primary carrier Explanation of Benefits / Payment. Refer to your Senior Preferred HMO contract for your claim filing limit.

10.2d Provider Payment Inquiries

Questions concerning claim status, claim payment, or adjustments should be directed to Customer Service at (800) 394-5566 or TTY 711.

Senior Preferred HMO prefers overpayment recovery through an electronic recoupment process. Questions regarding recoveries or recoupments resulting in a negative balance should be directed to the Claims Administration at (800) 394-5566.

10.2e Electronic Claim Submission

Senior Preferred HMO has contracted with a clearinghouse to accept institutional and / or professional electronic claim transactions. Claims are received on a daily basis. The providers should request from the patient their current insurance card to ensure that the claims are submitted with correct identification data. Claims submitted with missing data elements or inaccurate data will be rejected by the clearinghouse or denied as billing errors in the claim adjudication process.

10.2f Adjustments

Senior Preferred HMO shall have the right to make, and Facility shall have the right to request, corrective adjustments to prior payments; provided that Senior Preferred HMO shall have no obligation to pay any sum requested more than 12 months after the date upon which the claim was originally paid or the date upon which Senior Preferred HMO discovered the overpayment. Senior Preferred reserves the right to request monies for

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any overpayment to Provider that occurred within six years from the date the overpayment was received in accordance with 42 CFR 401.301(f). Senior Preferred will work with the Provider if compliance with this regulation is required and requests an overpayment for claims originally paid more than 12 months prior. If Senior Preferred HMO determines that an overpayment was the result of fraud or abuse, or if provider failed to provide full and timely cooperation with any audit by Senior Preferred HMO that could have revealed the overpayment, then Senior Preferred HMO may recover the overpayment without regard to such 12-month deadline. Each Party shall promptly report to the other Party any overpayment or underpayment of which they become aware. Any undisputed underpayment or overpayment shall be paid within 60 days of notice of the underpayment or overpayment. Senior Preferred HMO may offset any overpayment against any future payments to provider.

10.2g X12 Version 5010 Compliance Standards

Full compliance with the 5010 was required January 1, 2012, for all HIPAA-covered entities such as health plans, health care clearinghouses and health care providers to conform to the X12 “Version 5010” transaction standards as required by law. The 5010 is the set of standard transactions that regulates the electronic transmission of specific health care transactions, including eligibility, claims, claims status, referrals and remittances. If you have questions on these compliance requirements, please review the reference material given below –

Centers for Medicare & Medicaid Services

- www.cms.gov
- Medicare Claims Processing Manual –
 - Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims
- Medicare Electronic data interchange Part A Helpline –
 - State of Iowa: Phone 866-503-9670; website: www.wpsmedicare.com
 - State of Minnesota: Phone (800) 967-7902
 - State of Wisconsin: Phone (414) 226-6032
- Medicare Electronic data interchange Part B Helpline –
 - State of Iowa: Phone (866) 503-9670; website: www.wpsmedicare.com
 - State of Minnesota: Phone (877) 380-7442
 - State of Wisconsin: Phone (877) 567-7261
- Medicare Electronic data interchange DME Claims –
 - All States: Phone (866) 311-9184; website: www.ngscedi.com

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Billing Guides

- National Uniform Billing Committee (NUBC) — Institutional Claim Form Reference Manual
- National Uniform Claim Committee (NUCC) – 1500 Claim Form Reference Instruction Manual
- ASC X12 Version 5010 Insurance Committee Implementation guides for 837I and 837P.
- Uniform Billing Editor
- Medicare Claims Processing Manual:
 - Chapter 25 – Completing and Processing Form CMS-1450
 - Chapter 26 – Completing and Processing Form CMS-1500

New Requirements for 5010

The following new required fields for 837 claim transactions must be submitted as described below for both electronic and paper claim submission –

- National Provider Identifier (or identifiers for atypical providers): Report the National Provider identifier (NPI) for all providers listed on the claim. Atypical providers will use the provider secondary identifier element.
- Street address / physical location: The Billing Provider Address must be a physical address (for example, a street address). PO boxes or lockboxes cannot be submitted in the Billing Provider Address loop or Box 33 of the CMS 1500 claim or Field 1 of the UB-04 claim forms.
- Anesthesia claims: All anesthesia claims submitted using an 837 Professional or CMS 1500 claim form must be submitted in minutes for procedure code range of 00100 to 01969.
- 9-digit ZIP code: A 9-digit ZIP code must be submitted in the Billing Provider and Service Facility location loops or Boxes 32 and 33 of the CMS 1500 claim and Field 1 of the UB-04 claim forms.

Common Errors in 5010 Transactions

- The Billing Provider Address contains a PO Box.
- Rendering Provider information must be different than the Billing Provider.
- Service Facility and Billing Provider information must be different.
- The billing provider taxonomy code is either missing when required or invalid.
 - The billing provider taxonomy code is required when the provider has multiple certifications or enrollments on file with the specific payer.
 - The provider taxonomy code is a secondary identification number assigned by the specific payer or third party and is needed by the payer to identify the provider.
 - The provider taxonomy code also enables the payer to determine provider's type, classification, and / or area of specialization.
 - Please make sure to include the appropriate provider identification code if required for you or your organization. Your provider identification codes

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should be included with your provider enrollment agreement documents which are also on file with CMS.

Claims that do not meet the 5010 compliance requirements will be denied as provider responsibility with Claim Adjustment Reason Code 16 [Claim/service lacks information which is needed for the adjudication] and will need to be resubmitted with the correct or missing elements.

ICD-10-CM

All parties covered by HIPAA will be required to adopt ICD-10-CM codes for services provided on or after October 1, 2015. In order to process ICD-10-CM claims and other transactions electronically, providers, payers and vendors must first implement the "Version 5010" health care transaction standards mandated by HIPAA. The previous HIPAA "Version 4010/4010A1" transaction standards do not support the use of the ICD-10-CM codes.

ICD-10-CM information sources –

- American Academy of Professional Coders (AAPC)
- American Health Information Management Association (AHIMA)
- Workgroup for Electronic Data Interchange (WEDI) to identify webinars available for physician practices

10.2h Home Health and Nursing Home Reporting Requirements

Senior Preferred, as a Managed Care Organization, is required to submit Health Insurance Prospective Payment System (HIPPS) codes for all adjudicated skilled nursing (SNF) and home health (HH) encounters to CMS. Claims are required to be submitted with a valid HIPPS code. If a valid HIPPS code is not submitted, the claim will be denied as provider responsibility (with Claim Adjustment Reason Code 16 – Claim / service lacks information, which is needed for adjudication) and a corrected claim will need to be submitted using claim frequency value of 7.

- Skilled nursing facilities should submit revenue code 0022 with the appropriate HIPPS code and a dollar value of \$0.00. If no assessment was done, use HIPPS default code AAA00.
- HH Agencies should submit revenue 0023 with the appropriate HIPPS code and a dollar value of \$0.00. If no assessment was done, use HIPPS default code 1AFKS.

Home Health agencies must report a code indicating the location of where the services were provided. Report a service line on the claim with the appropriate revenue and Q5001, Q5002 or Q5009 with a charge of \$0.01. If the Q-code is not reported the claim will be denied as provider responsibility (with Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication) and a corrected claim will need to be submitted using claim frequency value of 7. Please refer to the most recent Med Learn Matters on the CMS website for detailed information.

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These instructions comply with the current information available from CMS and are subject to changes as Encounter Data Requirements are updated and clarified with CMS.

10.2i Distinct Procedural Services Modifiers – X(EPSU)

As defined by the AMA, under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day. The modifier -59 is used to identify procedures / services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision / excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only when there is not a more descriptive modifier available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used.

CMS defined four HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows –

- XE Separate Encounter, A Service That is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure, A Service That is Distinct Because It Was Performed On A Separate Organ / Structure
- XP Separate Practitioner, A Service That is Distinct Because It Was Performed By A Different Practitioner
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

These modifiers, collectively referred to as –X (EPSU) modifiers, define specific subsets of the -59 modifier. Senior Preferred will continue to recognize Modifier -59 and would expect its use to be minimal since CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available.

Reporting modifier -59 and its –X (EPSU) subset is important for the adjudication of the claim as it may allow payment when reported correctly and will not be subject to procedure unbundling edit rules (i.e., NCCI or code editing software). Senior Preferred accepts modifier -59 and requires reporting of the –X (EPSU) subset but not always to determine reimbursement. Following industry standards, Multiple and Bilateral Surgery Payment Reduction Guidelines will apply to these modifiers for services performed. Incorrect reporting of modifiers may result in claim or service denials.

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10.2j Code Edit System (CES) Denials

Corrected claims will deny as duplicate claims if the claim does not state it is a corrected claim in CLM05-3

Bundling edits follow the CMS NCCI practitioner procedure to procedure bundling edit rules

- CMS updates NCCI quarterly
- Modifier required on bundled codes, along with supporting documentation
- Modifier indicator of 0 means a modifier is not allowed
- Modifier indicator of 1 means a modifier is allowed

Inappropriate Modifier denial

Claim will deny with this if the modifiers reported are not appropriate to report with the claim line item CPT/HCPCS. Rationale is based on publications from CMS, the AMA, and CPT. The RT/LT modifiers are only appropriate on codes involving a single paired body organ and are not appropriate for use on codes that include the term “bilateral” in their description.

E/M billed without appropriate modifier

Claim line denied as E/M reported with a surgery without an appropriate modifier. Modifier appended is based on whether surgery has a 0-, 10- or 90-day global surgery period. E/M documentation must support the modifier.

- 0- and 10-day global require modifier 25 on E/M
- 90-day global surgery period includes the day prior to the surgical procedure. Requires modifier 54 on E/M

10.3 NON-COVERED SERVICES NOTIFICATION

Senior Preferred is obligated to follow Medicare policies. If the service is not covered by Medicare Fee-For-Service, it will not be covered by Senior Preferred. If Senior Preferred covers a service that Fee-For-Service does not, it will be specifically listed in the member’s EOC, which is available on the Member page at SeniorPreferred.org.

All providers (medical staff and suppliers) must obtain Prior Authorization for services listed on the Prior Authorization grid which is available online at SeniorPreferred.org/for-providers

Senior Preferred has created a flow chart for providers to follow for dispensing DME (Senior Preferred DME Prior Authorization Process). It is important to note, that medical staff (MD, PA, NP) must also call for Prior Authorization when ordering DME. This document can also be found under the provider forms tab of our website.

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As a contracted provider with Senior Preferred HMO you are required to complete the Notice of Denial of Medical Coverage (NDMC) prior to providing a non-covered service to a member. CMS requirements indicate that the member or the beneficiary must be held harmless for plan directed care. If you provide a non-covered service or referral to our member, you must discuss this with the member prior to the service being rendered and document the discussion in the patient's medical record in order for you to be able to bill the member. CMS does not allow the Medicare Advantage contracted providers to use the CMS ABN forms for non-covered services. Senior Preferred HMO has created the NDMC using the Integrated Denial Notice, Form CMS 10003-NDMCP (Iss. 06/2013) OMB Approval 0938-0829. You can find the notices on our website for use when providing these non-covered services. You should not submit a claim to Senior Preferred for services that are always non-covered (unless the beneficiary requests a claim to be filed). If a service is typically non-covered, but could be covered under certain conditions then a claim is required to be filed with the appropriate modifier indicating that you have provided the member the NDMC and have a copy on file. Claims submitted without the appropriate modifiers attached will be denied as provider responsibility, regardless if you obtained the notice or documented in the medical record.

10.4 MEMBER FINANCIAL PROTECTIONS

10.4a Related to Plan-Directed Care

CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005, final rule (CMS-4069-F): "MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

Consequently, when a contracted provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from the plan.

If a contracted provider refers a member to a non-contracted provider for a service that is covered by the plan upon referral, the member is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring a member to a non-contracted provider to ensure, to

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the extent possible, that members are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

A Member, or a provider acting on behalf of the member, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies a member's (or his / her treating provider's) request for coverage as part of the organization determination process, the plan must provide the member (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003), see Chapter 13 of the MMCM located at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf>. As a contracted provider, you are required to use a Notice that CMS has approved for Senior Preferred, which is available online at SeniorPreferred.org/for-providers.

If a service is never covered by the plan and the plan's EOC provided to the member is clear that the service or item is never covered, the plan is not required to hold the member harmless from the full cost of the service or item. For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The member has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise members when providing referrals for covered services. This will prevent confusion related to plan coverage and member financial liability as well as ensure coordination of the care furnished.

When the provider or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan; or that coverage is available only if the member is referred for the service by a contracted provider, but the member nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the member harmless from the full cost of the service or item charged by the provider.

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10.4b Non-discrimination to Dual Eligible Members

Medicare Advantage providers must not discriminate against members based on their payment status, i.e., Qualified Medicare Beneficiaries (QMB) or refuse to service members because they receive assistance with Medicare cost-sharing from a State Medicaid program. Federal law prohibits Medicare providers from collection Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the QMB program, a dual eligible program that exempts members from Medicare cost-sharing liability. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B, low income subsidy copayments still apply for Part D benefits. Senior Preferred will use this complaint procedure and issues identified through the CMS complaint Tracking Module to monitor compliance with balance billing rules and provide education to providers not abiding by the rules set forth in the 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, 42 C.F.R. 422.504(g)(1)(iii) and the Medicare Managed Care Manual, Chapter 4, Section 10.5.2.

10.4c Medicare Outpatient Observation Notice (MOON)

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to Senior Preferred members receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status with regard to cost-sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Hospitals and CAHs are required to furnish the Medicare Outpatient Observation Notice (MOON) to a member who has been receiving observation services as an outpatient. You can find this notice on the provider home page at SeniorPreferred.org, Under CMS's final NOTICE Act regulation, published August 2, 2016, hospitals and CAHs may deliver the MOON to members receiving observation services as an outpatient before such member has received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release. An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the paper notice, and a signature must be obtained from the member or a person acting on such member's behalf, to acknowledge receipt. In cases where such member or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

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SECTION 11: PROVIDER PAYMENT GUIDELINES

11.1 Payment under the RUGS methodology

All inpatient Part A services are paid under a prospective payment system (PPS) using a patient classification system of Resource Utilization Groups (RUGS) established and maintained by CMS. Reimbursement shall be 100 percent of said stated rate.

All covered Part A services that are considered within the scope or capability of the skilled nursing facility (SNF) are considered part of consolidated billing (CB) and paid under Part A Facility PPS rate. In some cases, the SNF must obtain some services it does not provide directly. Neither the SNF nor another provider or practitioner may bill Senior Preferred for services under Part B, except for services specifically excluded from PPS payment and associated consolidated billing requirements.

Covered services excluded from CB and subject to payment consideration by Senior Preferred are established and maintained by CMS. The HCPC procedure codes representing these excepted services separately billable under Part B can be found on the CMS website under SNF Consolidated Billing. HCPC procedure codes excluded from CB are updated as frequently as quarterly and are provided via various CMS online resources.

Senior Preferred, at its discretion, will consider payment for services included in CB for a network SNF for certain high-cost drugs, oncology services and other services. Consideration of payment will only be allowed when the anticipated high-dollar service exceeds 60 percent of the daily RUGS payment. Payment for these services will be at 60 percent of the amount that exceeds the daily RUGS payment. Payment will not exceed \$125 above the daily RUGS payment for any given service. Each service must be discussed with Senior Preferred as soon as possible after the member is admitted to the SNF. See examples of payment consideration.

Example 1

60% of a \$500 daily RUGS payment is \$300
High-dollar service part of CB is \$400, which exceeds 60% of \$500
Senior Preferred will consider payment of \$60, which is 60% of \$100 (\$400-\$300)

Example 2

60% of a \$500 daily RUGS payment is \$300
High-dollar drug part is \$5000 (80 tablets - 2 tablets, 2 times per day = 20 days)
20 days for \$5000 = \$250 per day
\$250 does not exceed 60% of \$500
Senior Preferred will not consider additional payment

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SECTION 12: GLOSSARY

12.1 COMMON TERMS

Accessibility. The extent to which a member of a health plan can obtain available services.

Acute Care. A level of health care that can be provided only in a hospital.

Adjudication. Determination of allowance on a claim based on type of coverage and use of benefits.

Amendment. A legal document that is used to change terms of a contract.

Appeal. Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service. These procedures include reconsideration by Senior Preferred HMO and if necessary, an independent review entity, hearings before the Administrative Law Judges, review by the Departmental Appeals Board, and judicial review.

Authorized Representative. An individual authorized by the member to act on their behalf in pursuing payment of a claim, obtaining a referral / Prior Authorization or dealing with any level of the grievance process.

Care Management. A process of identifying members with special health care needs, developing a health-care strategy that meets those needs, and coordinating and monitoring care. By offering alternatives to high cost settings or treatment, Care Management provides an opportunity to contain costs and still maintain the appropriate level of services.

Clinical Privileges. Authorization by the governing body for a practitioner to provide specific patient care and treatment services in the organization, based on the practitioner's license, education, training, experience and competence.

Clean Claim. A claim that has no defect, impropriety, or lack of any required substantiating documentation. A clean claim contains all the data elements required on an industry standard CMS claim form. For claims submitted to Plan electronically, Provider shall transmit claims in compliance with the requirements set forth in 45 CFR Parts 160 and 162 (the HIPAA requirement for standard transactions), or as are amended from time to time. A submission which does not include all the required information, or for which we must request additional information (for example, medical records, other coverage information or subrogation information) is not a clean claim until plan receives the required information.

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Coinsurance. A charge expressed as a percentage of the fee for covered expenses that members are required to pay for certain covered expenses provided under the policy. Members are responsible for the payment to the provider for any coinsurance charge.

Concurrent Review. A type of utilization review that occurs while treatment is in process and typically applies to services that continue over a period of time.

Confinement / Confined. The period of time between admission and discharge as an inpatient or outpatient to a hospital, alcohol, and other drug abuse residential treatment center, skilled nursing facility, or freestanding surgical facility. Confinement shall also include time spent in a hospital receiving care for a sickness or injury. Hospital swing bed confinement is considered the same as confinement in a skilled nursing facility. If patients are confined and transferred to another facility for continued treatment of the same or related condition, it is considered one confinement.

Coordination of Benefits (COB). A method of integrating benefits payable under more than one group health care program so that benefits from all sources do not exceed 100 percent of allowable expenses.

Copayment. A specific amount, usually expressed in dollars, or a charge for a service, that members must incur before Senior Preferred HMO assumes any liability for the remaining part of the charges for that service.

Corrective Action. A quality management process that is implemented to address complaints or errors for the purpose of eliminating future occurrences.

Cosmetic Surgery. Any operative procedure performed primarily to: improve physical appearance; to treat a mental or nervous disorder through a change in bodily form; to change or restore bodily form without correcting or materially improving a bodily function.

Covered Expense. An expense for medical services, supplies or treatment for which a fee or charge is incurred by or on the member's behalf because of injury or sickness, and for which Senior Preferred HMO provides a benefit. The expense is incurred on the date the service is performed or the supply or treatment is received. Covered expenses: 1) must be incurred while this coverage is in force for the members; 2) must be medically necessary; 3) must be listed as a covered expense in the member's certificate; 4) must not be excluded from coverage; 5) must not exceed any maximum amount payable under the member's certificate; and 6) must be received from a participating provider, or a non-participating provider with a prior approved written referral.

Credentialing. The process by which Senior Preferred HMO evaluates and recommends practitioners who are licensed to practice independently, to provide services to its members. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with Senior Preferred's utilization and QM requirements.

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Custodial Care. Such care does not entail or require the continuing attention of trained medical personnel, such as nurses. Custodial Care includes the provision of room and board, nursing care, personal care, or other care designed to assist an individual in the activities of daily living, such as help in: walking; getting in and out of bed; assistance in bathing or dressing; eating; using the toilet; preparing special diets; or supervision of medication, which usually can be self-administered. Care may still be custodial, even though such care involves the use of technical medical skills, if such skills can be easily taught to a layperson. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other care, which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the physician, that medical or surgical treatment will enable that person to live outside an institution. Custodial care includes rest cures, respite care and home care provided by family members.

Deductible. The amount the member must pay for covered services before Senior Preferred HMO assumes liability for all or part of the remaining costs for covered services. The deductible is an annual out of pocket expense for the member.

Disease Management. A coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality health care for a patient population who have or are at risk for a specific chronic illness or medical condition.

Disenrollment. Disenrollment means that a member's coverage under the policy is being terminated.

1. **Durable Medical Equipment.** Equipment that must be able to withstand repeated use.
2. Be primarily and customarily used to serve a medical purpose.
3. Not be generally useful to a person, except for the treatment of an injury or sickness.
4. Be medically necessary.

Examples include, but are not limited to: crutches; wheelchairs; hospital beds and equipment used in the administration of oxygen; initial acquisition of artificial limbs or eyes; and custom-made orthotics.

Effective Date. The date on which the member became enrolled and entitled to the benefits specified in the policy.

Electronic Data Interchange (EDI). The computer-to-computer transfer of data between organizations (provider, payer, clearinghouse) using a standard data format.

Eligibility. The right to receive benefits based on the type of contracts held.

Emergency Services. Services related to a medical condition involving acute symptoms that would lead a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention would result

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in serious jeopardy to the person's health, impairment to bodily functions, or serious dysfunction to one or more organs.

Exclusions. Contract provisions, which cite situations, conditions or treatments that are not covered.

Expedited Grievance. Expedited Grievance means a grievance where the standard resolution process may include any of the following: 1) serious jeopardy to the member's life or health or your ability to regain maximum function; 2) in the opinion of a physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; or 3) it is determined to be an expedited grievance by a physician with knowledge of the member's medical condition.

Experimental or Investigational. Treatments, procedures, drugs or medicines, which are experimental or investigational, and includes one or more of the following: 1) the device, drug or medicine cannot lawfully be marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug or medicine is furnished; 2) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing Phase I, II, or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy compared with the standard means of treatment or diagnosis; or 3) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedures, device, drug or medicine, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility, or the protocols of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Explanation of Benefits (EOB). A statement sent to the member explaining action taken by Senior Preferred HMO regarding a claim filed on his or her behalf.

Fee Schedule. A listing of established allowances for specific procedures. It usually represents either standard or maximum amounts the insurer pays.

Formulary. A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by Senior Preferred HMO providers in prescribing medications to members.

Grievance. Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Senior Preferred HMO

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provides health care services, regardless of whether any remedial action can be taken. A member may make the complaint or dispute, either orally or in writing, to the Senior Preferred HMO provider, or facility. A grievance may also include a complaint that Senior Preferred HMO refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frames.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and / or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards of delivery of health care.

Health Maintenance Organization (HMO). An organized system for providing health care in a geographic area that assures delivery of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of people for a predetermined, fixed prepayment fee.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (August 21), Public Law 104-191, which amends the Internal Revenue Service Code of 1986. Also known as the Kennedy-Kassebaum Act.

Locum Tenens. A practitioner who is replacing a plan affiliated practitioner for a specified period of time while the plan provider is absent from their practice.

Maintenance Therapy. Ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau, or improvement in his / her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes maintenance therapy is made by Senior Preferred HMO after reviewing an individual's case history or treatment plan, submitted by a health care provider.

Medical Director. A physician employed by Senior Preferred HMO to direct and manage the delivery of appropriate medical care in a cost-effective manner while maintaining the highest quality of care possible.

Medical Management. A department within Senior Preferred HMO consisting of health professionals who provide referral management; Prior Authorization, concurrent review of hospitalizations, and case management.

Medically Necessary. Medical treatment, services or supplies that are required to identify or treat a sickness or injury and which, as determined by Senior Preferred HMO are –

1. Consistent with the symptoms, diagnosis or treatment of the patient's medical condition;
2. Appropriate with regard to standards of good medical practice;
3. Not primarily for the member's convenience, their immediate family, or that of the physician or another provider;

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4. The most appropriate and cost-effective level of medical service or supplies, which can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided as an outpatient; and
5. Have proven value or usefulness.

The fact that a physician or participating provider has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed members of its availability, does not in itself make it medically necessary.

Medicare Advantage [Organization]. An entity licensed by the state as a risk-bearing entity that is contracted with the Centers for Medicare and Medicaid Services, to provide a network of providers through contractually specified reimbursement terms for covered benefits for Medicare eligible beneficiaries.

Appeals Specialist. An individual employed by Senior Preferred HMO specializing in the appeal and grievance process.

Members. Individuals for whom Senior Preferred HMO has a contractual obligation to provide or arrange for the provision of health services.

National Committee for Quality Assurance (NCQA). The not-for-profit, District of Columbia-based organization that is widely recognized as the authority on quality for managed care organizations. NCQA has developed over 50 standards in six categories (Quality Improvement, Credentialing, Utilization Management, Preventive Health Services, Members' Rights and Responsibilities and Medical Records) and evaluates internal quality processes through accreditation site visits.

Network. The physicians and other professional providers, clinics, health centers, and hospitals that a managed care organization has affiliated and contracted with to provide care to its members.

Non-Participating Provider. Refers to a physician or other health care practitioner who has not signed a participating provider contract with Senior Preferred HMO to provide medical treatment, services or supplies, to members. Except for emergency care, benefits are excluded when you receive medical treatment, services or supplies, from a non-participating practitioner / provider without a written referral from a participating practitioner / provider, which was been approved in writing by our Medical Director.

Observation Status. Observation status means a stay in a hospital or qualified treatment facility not to exceed 48 hours if –

1. Member has not been admitted as an inpatient;
2. Member is physically detained in an emergency room, treatment room, observation room, or other such area; or
3. Member is being observed to determine whether an inpatient confinement will be required.

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Out-of-Network. Physicians and other professional practitioners, clinics, health centers and hospitals not in a particular network. Members usually must obtain prior approval or pay a higher copayment when using an out-of-network practitioner / provider.

Participating. Refers to a status when a provider/practitioner of health care services has signed a contract to participate in Senior Preferred's network.

Participating Professional. Is used in reference to the following practitioners only: Emergency Medicine MD or DO, Pathologists, Certified Registered Nurse Anesthetists (CRNA), Advanced Nurse Practitioners with an inpatient practice only, Anesthesiology Assistants.

Participating Provider. A health care facility, institution or clinic that agrees by contract to provide services for members.

Peer Review. The evaluation by practicing physicians or other health care providers of the effectiveness and efficacy of services provided by other members of the same profession.

Plan. An insurance group, health care organization or worker's compensation program, which contracts with providers / practitioners for health care services.

Practitioner. A health care individual who agrees by contract to provide services for members.

Prior Authorization / Prior Authorized. The process of obtaining prior written approval from Medical Management as to the appropriateness of a service or medication. Prior Authorization does not guarantee coverage.

Provider Services Agreement. A legal contract between Senior Preferred HMO and a provider citing legal responsibilities of both parties.

Referral. The formal process that authorizes a member to seek care from a non-affiliated out-of-network practitioner / provider without incurring additional fees.

Routine Exams / Routine Examination. Any physical exam or evaluation done in accordance with our preventive care guidelines indicated for age and gender.

Service Area. The geographic area in which participating providers / practitioners are located.

Skilled Care. Medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist. **Skilled Nursing Facility (SNF).** An institution that is licensed by the state of Wisconsin or other applicable jurisdiction, which maintains and provides the following –

1. Permanent and full-time bed care facilities for resident patients.
2. A physician's services available at all times.

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3. A registered nurse or physician in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty.
4. A daily record for each patient.
5. Continuous skilled care for sick or injured persons during convalescence from sickness or injury.

Unbundling. A coding inconsistency that is a non-industry standard, which involves separating a procedure into parts and coding / charging for each part rather than using a single code for the entire procedure.

Urgent Care. Care for an injury or sickness that is needed sooner than a routine doctor's visit.

Utilization Management (UM). Managing the use of medical services to ensure that a patient receives necessary, appropriate and high-quality care in a cost-effective manner.

Utilization Review. An evaluation of the necessity, appropriateness and efficacy of the use of medical or institutional services.