



SECUR, Inc. d/b/a
SECUR Health Plans
2026 Provider Manual

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Provider Manual

Section 1.0

Introduction

1.0 Introduction to SECUR Health Plan

Welcome to the SECUR Health Plan Provider Network community! SECUR's goal is to provide Medicare-eligible individuals with the care, services, information, and wellness programs they need to achieve optimal health. At SECUR, our mission is to revolutionize healthcare for individuals with complex needs through our specialized Medicare Advantage Institutional Special Needs Plan (I-SNP). Committed to enhancing the quality of life for our members, we aspire to be a trusted partner in their healthcare journey by delivering comprehensive, person centered, and innovative solutions.

SECUR is a Health Maintenance Organization, with a Centers for Medicare & Medicaid Services (CMS) contract, which offers Medicare Advantage and Prescription Drug Plans (MA-PD). SECUR offers MA-PD products in select counties in Florida. SECUR's plans are subject to annual renewal and approval by CMS. You can learn more about SECUR's service areas by visiting our website www.securhealthplan.com.

1.1 Provider Welcome

We are pleased to welcome you to the SECUR Provider Network. As a participating provider or entity, you play an important role in supporting access to high-quality, cost-effective services for SECUR members. SECUR values its partnerships and recognizes that achieving our mission depends on collaboration across our provider network.

The Provider Manual outlines SECUR's policies, administrative procedures, and operational requirements. It serves as a reference for topics such as member benefits, claims submission, and other day-to-day processes, and supports the requirements set forth in the applicable agreement with SECUR. In the event of any inconsistency, the applicable agreement will govern.

The Provider Manual is updated periodically and posted on SECUR's website. Network participants are responsible for reviewing and complying with all updates, including provider alerts, medical office notes, and other communications issued by SECUR.

All SECUR provider materials, including the Provider Manual and Provider Directory, are available online at securhealthplan.com. For purposes of the Provider Manual, the term "provider" includes all individual practitioners, practitioner groups, facilities, and ancillary service providers, as applicable.

https://carenu-my.sharepoint.com/personal/ochmanp_carenu_com/Documents/P-Drive/SECUR/Providers/Manual/securhealthplan.com

1.2 Medicare Advantage and Prescription Drug Plans (MA-PDs)

SECUR is a managed care organization that administers coverage that encompasses all Original Medicare benefits plus additional benefits identified in SECUR's Plan Benefit Packages (PBP). Additional benefits include, but may not be limited to:

- No or low monthly premiums
- Low copays or coinsurance for in-network services
- Prescription drug coverage
- Routine dental, vision, hearing
- \$0 copay preventive care services

SECUR's PBPs may change each year and may be based on the defined service area. You can find SECUR's PBP information on its website securhealthplan.com.

1.3 SECUR Products

Below is a list of SECUR's MA-PD products. The list may change from year to year.

Health Maintenance Organization (HMO) – Traditional MA-PD plan. All services must be provided within SECUR's Provider Network, except for emergency or urgently needed care, or in the event the service is not available in-network. Some services require prior authorization by SECUR.

*See Section 5.4 of this Provider Manual to review SECUR's rules for plan-directed care.

Institutional Special Needs Plan (I-SNP) – An I-SNP plan is not a traditional Medicare Advantage product. It is designed to go beyond the basic provisions of Medicare Parts A/B services and standard care coordination that are required of all traditional Medicare Advantage plans. Although it exists in both Model of Care and Quality Improvement Programs, I-SNPs are designed to restrict enrollment to individuals who live in institutional settings, such as a skilled nursing facility, or within the community, such as an assisted living facility. Individuals eligible for I-SNPs have an institutional level of care need and require specialized delivery systems across domains of care; and live within the plan service area.

1.4 Standard Terms and Conditions

The Provider Manual (the "manual") is incorporated by reference into and forms part of the provider agreement between the provider and SECUR. The manual sets forth the policies, procedures, and operational requirements applicable to the administration of SECUR's Medicare Advantage Prescription Drug (MA-PD) plans.

The Provider Manual may be updated from time to time. Upon posting an updated version on SECUR's website, the updated Provider Manual shall supersede and replace all prior versions, policies, and procedures. Providers are responsible for reviewing and complying with the most current version of the Provider Manual.

All terms used in this manual are defined in the definitions or acronyms section of this manual or in the Provider Agreement.

1.5 Notification of Change

Unless otherwise specified in the applicable agreement, entities participating in the SECUR Provider Network must notify SECUR in writing within ten (10) days of any change described below.

1.5.1 Hospitals

Hospitals must notify SECUR of any change to the following:

1. Facility or office address
2. Billing address
3. Telephone number
4. Hospital vendors, including the addition or removal of any hospital vendors
5. Legal name or fictitious name (DBA)
6. Taxpayer identification number (TIN)
7. Ownership
8. E-mail address

Hospitals must also notify SECUR of any reduction in the scope of hospital services. A material reduction in the scope of hospital services, as determined by SECUR, may be deemed a material breach of the facility agreement.

1.5.2 Providers

Providers must notify SECUR of any change to the following:

1. Office or facility address
2. Billing address
3. Telephone number
4. Provider staff, including the addition or removal of any provider staff
5. Legal name or fictitious name (DBA)
6. Taxpayer identification number (TIN)
7. Office location
8. Office hours
9. Ownership
10. Group affiliation
11. E-mail address

Providers must also notify SECUR of the death of a provider staff member or any loss, suspension, or restriction of licensure.

If a provider or hospital changes its billing address or taxpayer identification number, SECUR must be notified of the effective date of the change and provided with a signed and dated IRS Form W-9. Notices must be sent to SECUR's Contracting Department via email at **contracting@securhealthplan.com**.

1.6 Independent Contractor Relationship

SECUR administers its Medicare Advantage Prescription Drug (MA-PD) plans in accordance with the benefit packages approved for each SECUR Medicare plan. To support member access to covered services, SECUR arranges for healthcare and related services to be furnished by independently contracted providers, facilities, hospitals, and ancillary service entities. Services are delivered by the participating entity and not by SECUR.

Pursuant to the applicable agreement, SECUR and each participating entity operate as independent contractors. Nothing in this manual or in the applicable agreement is intended to create an employment, agency, partnership, or joint venture relationship. Each participating entity is solely responsible for its operations, personnel, services, and the delivery of services to members.

SECUR's role includes administering plan benefits and making coverage determinations, such as whether a service is covered under the applicable plan and whether authorization or other administrative requirements apply. These determinations are made solely for benefit administration and payment purposes and do not direct, control, or replace the independent judgment or operational decisions of the entity furnishing services to members.

1.7 Protocols and Guidelines

Decisions made by SECUR in the administration of the applicable agreement, including determinations regarding whether a service is a covered service, are made solely for purposes of benefit administration and payment under the applicable SECUR Medicare plan.

The entities furnishing services to members are responsible for the services provided, including compliance with applicable laws, regulations, professional standards, and operational requirements. SECUR does not direct or control how services are delivered, and all service-related decisions remain the responsibility of the entity furnishing the services.

Members should be encouraged, as applicable, to review their SECUR Medicare plan Evidence of Coverage for information regarding covered benefits, procedures, and any applicable exclusions or limitations prior to receiving services. Evidence of Coverage and other member materials are available at www.securhealthplan.com.

1.8 Licensure

All entities furnishing services to members must maintain, in good standing, all licenses, accreditations, certifications, registrations, and permits required under applicable local, state, and federal laws and regulations, as well as the applicable agreement.

Provider Manual

Section 2.0

Provider Administrative Guidelines

2.0 Provider Administrative Guidelines

2.1 SECUR Provider Portal

SECUR offers secure, web-based tools through the Provider Portal to support participating providers and entities in conducting business with SECUR. The Provider Portal is designed to streamline administrative processes and provide convenient, secure access to information needed to support Member Services.

Participating providers and entities may use the Provider Manual to register for the Provider Portal by “*How to Register*” section below or by visiting <https://pm-secur.mirrahealthcare.com/> and selecting the **Providers option**

2.1.1 Provider Portal Features

SECUR’s secure Provider Portal provides access to key administrative functions. Participating providers and entities with an active account and appropriate permissions may use the portal to:

- **Member Eligibility and Benefits** — Verify member eligibility, and view co-pays, benefits, and demographic information.
- **Authorization Requests** — View authorization requests and related status information.
- **Claims Submissions Status** — Submit claims and review claim status.

2.1.2 How to Register

To access the SECUR Provider Portal, we require contact information for the individual designated to administer portal access for your organization. This individual will be responsible for setting up and maintaining user accounts.

SECUR will provide a registration form via email for completion and return, as instructed. Requested information may include:

1. Administrator First and Last Name
2. Administrator e-mail address
3. Administrator Contact Phone Number
4. Street Address
5. City, State and Zip Code
6. Tax identification number(s)
7. Provider, group, facility, or entity name(s)

For questions regarding the registration process or assistance with portal access, you may contact **1.352.277.5305** between **8 a.m.** and **5 p.m.**, Monday through Friday.

2.1.3 Provider Portal Resources

SECUR’s website offers a variety of resource materials to assist participating providers and entities in understanding Medicare requirements and SECUR plan policies. Available resources include:

- Provider Manual

- Quick Reference Guide
- Clinical Practice Guidelines (as applicable)
- Forms and documents
- Pharmacy and network lookup tools
- Authorization and referral requirements
- Training videos and materials
- Member Rights and Responsibilities (also available in Section 2.8 of this Provider Manual)
- Notice of Privacy Practices

2.2 Quick Reference Phone List

Resource	Contact Information
SECUR	
SECUR Member Services	1.833.76SECUR (1.833.767.3287)
Enrollment and Eligibility	1.833.76SECUR (1.833.767.3287)
Claims — Status	1.833.76SECUR (1.833.767.3287)
Prior Authorizations (phone or fax)	1.833.76SECUR (1.833.767.3287)
Grievance & Appeals (Members)	1.833.76SECUR (1.833.767.3287)
Provider Disputes (Contracted Providers)	1.833.76SECUR_(1.833.767.3287)
Provider Appeals (Non-contracted Providers)	1.833.76SECUR (1.833.767.3287)
EDI Vendor Provider Support	352.277.5305
Fraud, Waste, and Abuse Hotline	1.833.76SECUR (1.833.767.3287)
Health Services Quality Department	1.833.76SECUR (1.833.767.3287)
OTHER ORGANIZATIONS	
TTY	711
Nurse Advice Line	1.833.76SECUR (1.833.767.3287)
Pharmacy Benefit Manager (PBM) — Navitus (provider technical help desk)	1.866.270.3877
Navitus Prior Authorizations	1.844.268.9789
Dental (Members)	1.855.200.1555
Dental (Providers)	1.877.493.6292
Vision	1.800.849.3937

Transportation	1.877.917.3040
REGULATORY AGENCIES	
Florida Agency for Health Care Administration	850.412.4402
Florida Office of Insurance Regulation	850.413.3140
Florida Medicaid	1.877.711.3662
Office of Inspector General (OIG) — Fraud Line	1.800.447.8477

2.3 Compliance Requirements

2.3.1 Non-Discrimination

Provider shall comply with Title VI of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Federal Rehabilitation Act of 1973, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide, in part, that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds. All SECUR contracted providers must comply with all State and Federal Anti-discrimination laws including, but not limited to:

- Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000D et seq) and applicable 45 CFR Part 80 or 7 CFR Part 15
- Section 504 of the Rehabilitation Act of 1973 (29 USC 794) and Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq)
- Age Discrimination Act of 1975 (42 U.S.C. 6101-6107)
- Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or & CFR Part 16

2.3.2 Payment Integrity

SECUR maintains a comprehensive Payment Integrity Program designed to prevent, detect, investigate, and correct Fraud, Waste, and Abuse (FWA) in accordance with federal and state regulations, including the Federal False Claims Act, the Deficit Reduction Act, 42 CFR §§ 422.503 and 422.504, and applicable Medicare Advantage requirements. These laws impose civil penalties and damages against any individual or entity that knowingly submits or causes the submission of a false, fraudulent, or misleading claim to a federal health care program, including Medicare Advantage.

Under federal law, a person acts “knowingly” not only when they have actual knowledge of falsity but also when they act in deliberate ignorance or reckless disregard of the truth or falsity of the information. Intent to defraud is not required for liability to attach.

Examples of billing and coding practices that may constitute false claims include, but are not limited to:

- Billing for services not rendered.
- Billing for services that are not medically necessary.
- Billing for services that are not documented in the medical record.
- Upcoding or unbundling of services.
- Kickbacks, inducements, or improper financial arrangements

Penalties may include civil monetary fines, treble damage, and exclusion from participation in Medicare and Medicaid programs.

SECUR Payment Integrity Program

SECUR maintains an internal Payment Integrity Program consistent with CMS and NCQA program-integrity expectations. This program includes:

- Enforcement of standards through policies, procedures, and disciplinary guidelines
- Internal monitoring and auditing of members, providers, and subcontractors
- Oversight of first-tier, downstream, and related entities (FDRs)
- Processes to identify and correct billing outliers, patterns, and trends using analytics, algorithms, and claims edits.
- Processes for recovering overpayments, consistent with federal reporting and return requirements.
- Established procedures for disputes and appeals related to overpayment identification.
- Maintenance of auditable logs, documentation retention, and Information Integrity controls consistent with NCQA 2025 standards

The SECUR Compliance Department conducts investigations of suspected FWA and coordinates with appropriate regulatory and law enforcement agencies when required.

Provider Responsibilities

All providers must cooperate fully with SECUR's Payment Integrity and Compliance Programs. Provider responsibilities include:

- Cooperating with investigations, audits, record requests, and data validation activities
- Maintaining complete, accurate, and timely medical documentation
- Ensuring claims submitted to SECUR are truthful, accurate, and supported.
- Reporting suspected fraud, waste, or abuse immediately
- Ensuring employees and subcontractors complete annual CMS-required FWA and General Compliance training
- Maintaining internal controls to detect and prevent inaccurate billing.
- Protecting the integrity of all clinical and billing information

Reporting Suspected Fraud, Waste, or Abuse

Anyone, including providers, staff, members, vendors, and contractors, may report actual or suspected FWA. Reports may be made confidentially and without fear of retaliation. SECUR strictly prohibits intimidation or retaliation against any person who makes a good-faith report.

To report suspected FWA to SECUR:

- **Compliance Line:** 1.833.76SECUR (1.833.767.3287)
- **Mail:** SECUR Health Plan, Attn: Compliance Department, 12470 Telecom Drive, Suite 301, Temple Terrace, FL 33637
- **Email:** compliance@securhealthplan.com.

All reports are reviewed by the SECUR Compliance Department and kept confidential to the fullest extent permitted by law.

To report directly to federal authorities:

Office of Inspector General (OIG)

- **Phone:** 1.800.HHS.TIPS (1.800.447.8477)
- **Website:** <https://oig.hhs.gov/fraud/report-fraud/index.asp>

Annual Fraud, Waste, and Abuse Training Requirement

To comply with CMS regulations, all providers, contracted entities, and their employees must complete annual Fraud, Waste, and Abuse (FWA) training and general Compliance Training. Providers must maintain documentation of training completion and furnish evidence upon request.

2.3.3 Exclusion Screening

Exclusion screening is the process of verifying that a provider organization's current and/or potential employees are not classified as an excluded individual who is prohibited from participation in any Federal healthcare program. The OIG imposes exclusions under the authority of sections 1128 and 1156 of the Social Security Act. The principal effect of exclusion is that payment is prohibited for anything that an excluded individual furnishes, orders, or prescribes, and any administrative and management services furnished by the excluded individual. This prohibition extends to anyone who employs or contracts with the excluded individual. SECUR requires that its providers and facilities to:

- Conduct appropriate exclusion screening prior to hire, appointment, or contract of any new staff.
- Report all staffing roster updates to SECUR within 20 days prior to any new hires commencing work.
- Conduct appropriate exclusion screening monthly.
- Report any potential issues associated with a positive report of an individual being excluded from Federal healthcare programs to SECUR within five business days.

2.3.4 Compliance, Privacy, and Security

Providers must comply with current state and federal rules, including but not limited to the following:

1. Environmental protection laws:
 - a. Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.
 - b. National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 (“Protection and Enhancement of Environmental Quality”) relating to the institution of environmental quality control measures.
 - c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, “Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans”).
 - d. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act.
 - e. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water.
2. State and federal anti-discrimination laws:
 - a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15.
 - b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794).
 - c. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.).
 - d. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107).
 - e. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688).
 - f. Food Stamp Act of 1977 (7 U.S.C. §200 et seq.).
 - g. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16.
3. The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments.
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).
5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et. seq.

2.3.5 HIPAA Incident Reporting

Providers and facilities are required to review all member information received from SECUR to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a Provider or Facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately notify SECUR of the misrouted PHI and destroy the misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call SECUR’s Member Services at 1.833.76SECUR (1.833.767.3287).

2.3.6 Cultural Competency

SECUR Medicare members represent diverse languages, cultures, beliefs, and backgrounds. Participating providers and entities are expected to deliver covered services in a manner that is respectful, inclusive, and responsive to each member’s individual needs. This includes using clear, understandable communication, and providing appropriate assistance for members with limited comprehension, language barriers, or other communication needs.

Additional information regarding cultural competency requirements is available in Section 7.8 of this Provider Manual.

2.3.7 Member Hold Harmless Provisions

SECUR and Participating Entity Obligations

In accordance with the applicable agreement between SECUR and the participating entity shall not, and shall ensure that its contracted providers or subcontractors do not, under any circumstances including, but not limited to, nonpayment by SECUR or another payer, insolvency of SECUR or another payer, or breach of the applicable agreement, bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against a SECUR member or any person acting on behalf of the member for covered services.

Dual Eligible Member Hold Harmless

For members who are eligible for both Medicare and Medicaid, participating entities agree that SECUR members will not be held liable for Medicare Part A or Part B cost sharing amounts when such amounts are the responsibility of the applicable State Medicaid program.

Participating entities shall comply with all applicable Medicare and Medicaid requirements for individuals eligible for both programs and may not impose cost sharing that exceeds the amount permitted under Title XIX of the Social Security Act if the individual were not enrolled in a Medicare Advantage plan.

Participating entities must either:

1. Accept SECUR's payment as payment in full, or
2. Bill the appropriate State Medicaid agency, in accordance with applicable laws and regulations.

2.4 Provider Administrative Requirements

In accordance with accepted professional standards, applicable law, and the terms of applicable agreement, participating providers and entities shall:

- Comply with all applicable federal and state laws and regulations, including, without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, the False Claims Act, and the Anti-Kickback Statute.
- Cooperate fully with SECUR in monitoring compliance with CMS contracts and applicable CMS rules and regulations, including participation in corrective action plans as required.
- Maintain and retain all agreements, books, records, documents, papers, and other materials related to services furnished to SECUR members for the period required under the applicable agreement and applicable state and federal law.
- Maintain processes, as applicable to the services furnished, to support member access to covered services, including after-hours access when required under the applicable agreement.
- Support continuity of care and coordination of services during transitions, including referrals, admissions, discharges, and terminations, and cooperate with SECUR in facilitating such coordination.

- Respond timely and completely to SECUR requests for records, data, or information necessary to meet regulatory, audit, grievance, appeal, or oversight requirements.
- Permit SECUR to use performance, utilization, and quality data for quality improvement, utilization management, compliance, and regulatory reporting purposes.
- Cooperate with SECUR quality improvement, utilization management, and compliance activities.
- Ensure that any subcontract, delegation, or employment arrangements with physicians or other healthcare practitioners are memorialized in writing and impose obligations consistent with, and no less stringent than, those set forth in the applicable SECUR agreement.
- Maintain a safe and compliant service environment, including equipment in proper working order, in accordance with applicable local, state, and federal safety, health, and public hygiene requirements.
- Maintain accurate, complete, and confidential records and comply with all SECUR policies and applicable laws governing record content, privacy, security, and confidentiality.
- Communicate service-related or clinical information, as applicable to the services furnished, in a timely manner and provide requested information to SECUR, the member, or an authorized requesting party, without charge unless otherwise permitted by law or agreement.
- Not discriminate between SECUR Medicare Advantage members and other Medicare Advantage members.
- Not deny, limit, or condition the furnishing of services to any SECUR Medicare Advantage member based on health status or other protected characteristics, including, without limitation, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, or conditions arising from domestic violence.
- Comply with all applicable CMS Medicare Communications and Marketing Guidelines and obtain SECUR approval, when required, prior to issuing plan-related communications to members.
- Furnish covered services, when applicable, in accordance with professionally recognized standards of care.
- Utilize physician assistants and nurse practitioners, when applicable, in compliance with state scope-of-practice laws and SECUR guidelines and assume supervisory responsibility as required by law.
- Clearly identify professional credentials to members and other healthcare professionals, when applicable.
- Honor member requests to receive services from a physician, when required under applicable law or agreement.
- Preserve member dignity and support member understanding of diagnoses, prognoses, and treatment options, as applicable to the services furnished.

- Communicate openly with members regarding available treatment and non-treatment options, including alternatives, regardless of whether such options are covered services, when applicable.
- Identify members who may benefit from services related to domestic violence, smoking cessation, or substance use, when appropriate, refer members to SECUR-sponsored or community-based programs, when applicable.
- Document referrals and provide appropriate follow-up consistent with applicable professional standards and regulatory requirements, when applicable.

2.5 Insurance

Providers and hospitals shall maintain throughout the term, at their sole cost and expense, professional liability insurance and general liability insurance consistent with applicable law, SECUR credentialing criteria, and this manual as necessary to insure it and its employees and contractors against any and all claims for damages arising by reason of death or personal injuries occasioned directly or indirectly in connection with providers' or hospitals' acts or omissions in the performance of covered services pursuant to the agreement ("insurance"). Providers and hospitals shall, to the extent they are able to do so, obtain Insurance on an occurrence basis. If a provider or hospital obtains claims-made Insurance, such Provider or Hospital shall obtain "tail" coverage that is effective upon termination of the claims-made policy and a retroactive effective date of such policy to ensure there is no lapse in coverage. Providers and hospitals shall provide verification of compliance with this provision to SECUR upon SECUR's request. Providers and hospitals shall ensure that their liability insurance company is required to provide SECUR with fifteen (15) days prior written notice of cancellation, termination, or non-renewal of provider's or hospital's Insurance. The cancellation, termination, and/or non-renewal of a provider's or hospital's Insurance, as required under the agreement and this manual, shall be deemed to be a "material breach" of the agreement. Notwithstanding the foregoing to the extent permitted by applicable Florida law, in the event a provider or hospital does not maintain Insurance, such provider or hospital shall post all notices and statements relating to insurance coverage as required by applicable Florida law. Providers and hospitals shall immediately notify SECUR whenever a member files a claim or a notice of intent to commence legal action against such provider or hospital, if known to the provider or hospital, including the details of the nature, circumstances, and disposition of such claim. Such notice shall be sent to credentialing@securhealthplan.com.

2.6 Communication Materials

Any provider marketing for SECUR must be approved by SECUR in advance to ensure compliance with CMS guidelines. This mandatory review will include letters announcing affiliation with SECUR, plan availability, events, health fairs, etc. Any gifts or promotional items must also follow CMS guidelines. Contact your network representative for more information.

Providers may make available and/or distribute SECUR marketing materials, display posters, or other materials announcing SECUR contractual relationships in accordance with and subject to Medicare Marketing Materials Guidelines. However, providers may not make available, accept, or distribute plan enrollment applications or offer inducements to enroll in a specific plan. Providers shall not offer anything of value to induce a prospective member to select them as their provider.

2.7 Designated Liaison

Each provider's office shall designate an office manager or administrator as the primary contact for SECUR. This individual must have sufficient authority to ensure compliance with SECUR's contractual and administrative requirements.

2.8 Member Rights and Responsibilities

Providers and hospitals shall make available to member upon request a copy of the statement of member Rights and Responsibilities. In accordance with applicable laws and regulations, SECUR's statement of member rights and responsibilities is presented below:

The following rights and responsibilities are set forth under State law. State law requires that your healthcare Provider or healthcare Facility recognize your rights while you are receiving medical care and that you respect the healthcare Provider's or healthcare Facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare Provider or healthcare Facility. A summary of your rights and responsibilities follows:

Member Rights

- *You have the right to be treated with fairness, courtesy, and respect, with appreciation of your individual dignity, and with protection of your need for privacy, including the protection of your medical records and personal health information.*
- *You have the right to a prompt and reasonable response to questions and requests.*
- *You have the right to know who is providing medical services and who is responsible for your care.*
- *You have the right to know what member support services are available, including whether an interpreter is available if you do not speak English.*
- *You have the right to know what rules and regulations apply to your conduct.*
- *You have the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.*
- *You have the right to know your treatment choices and participate in decisions about your healthcare.*
- *You have the right to refuse any treatment, except as otherwise provided by law.*
- *You have the right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for your care.*
- *You have the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.*

- *You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.*
- *You have the right to receive a copy of a clear and understandable, itemized bill and, upon request, to have the charges explained.*
- *You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.*
- *You have the right to treat for any emergency medical condition that will deteriorate from failure to provide treatment.*
- *You have the right to know if medical treatment is for the purposes of experimental research and to give your consent or refusal to participate in such experimental research.*
- *You have the right to make complaints, which are either appeals or grievances related to your coverage or care.*
- *You have the right to see plan providers, get covered services, and your prescriptions filled within a reasonable time period.*
- *You have the right to use advance directives, such as a living will or power of attorney.*
- *You have the right to get more information about your rights by calling Member Services at the number listed on your member materials or 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. You can call Medicare 24 hours a day, seven days a week, or you can visit www.medicare.gov on the web to order Your Medicare Rights and Protections or print it directly from your computer. You can also view information concerning the HHS Office for Civil Rights online at www.hhs.gov/ocr or by calling U.S. Department of Health and Human Services (HHS) toll-free at 1.800.368.1019.*

Member Responsibilities

- *You are responsible for providing to the healthcare provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.*
- *You are responsible for reporting unexpected changes in your condition to the healthcare provider.*
- *You are responsible for reporting to the healthcare provider whether you comprehend a contemplated course of action and what is expected of you.*

- *You are responsible for following the treatment plan recommended by the healthcare provider.*
- *You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying the healthcare provider or healthcare facility.*
- *You are responsible for your actions if you refuse treatment or do not follow the healthcare provider's instructions.*
- *You are responsible for assuring that the financial obligations of your healthcare are fulfilled as promptly as possible, including premiums, if any, and copayments you may owe for covered services. You must also meet the financial responsibilities described in the Evidence of Coverage.*
- *You are responsible for following healthcare facility rules and regulations affecting your care and conduct.*
- *You are responsible for getting familiar with your coverage and the rules you must follow to get care as a member.*
- *You are responsible for acting in a way that supports the care given to others in the provider's office and helps the smooth running of your doctor's office, hospitals, and other offices.*

2.9 Member Services

SECUR offers Member Services for members, providers, and hospitals to answer questions regarding eligibility, copayment, claim status, authorization status, and benefit information.

Member Services hours are as follows:

October 1 – March 31:

- Live services representatives are available seven (7) days a week, from 8 a.m. to 8 p.m. (EST)
- Also, we may implement the use of an interactive voice response system or similar technologies available for Thanksgiving and Christmas Day with messages returned within one business day.

April 1 – September 30:

- Live services representatives are available Monday through Friday, from 8 a.m. to 8 p.m. (EST)
- Also, we may implement the use of an interactive voice response system or similar technologies for Saturdays, Sundays, and other Federal Holidays with messages returned within one business day.

Providers and hospitals are asked to call between 8 a.m. and 5 p.m. (EST) to discuss issues and concerns about claim payments and/or prior authorizations.

The telephone number for SECUR Member Services is 1.833.76SECUR (1.833.7673287). TTY is 711.

2.10 Translator and Interpreter Services

Help for those with impaired vision, hearing, or in need of interpreter services is available. The member welcome kit is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Teletype device (TTY), they can receive these services-by calling 711.

Providers should help coordinate interpreter services for members by contacting SECUR's Member Services to arrange appropriate assistance. Members can receive interpreter services at no cost to access covered services, including verbal translation, written translation of key SECUR plan materials, and sign language for the hearing impaired.

2.11 Pharmacy Call Centers

2.11.1 Technical Help

SECUR operates a toll-free pharmacy technical help call center to respond to inquiries from Pharmacies and Providers regarding the SECUR member prescription drug benefit. This call center is operated by our Pharmacy Benefits Management company, Navitus. These inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This call center is available twenty-four (24) hours per day, seven (7) days a week, closed on Thanksgiving and Christmas Day. The telephone number for the SECUR Pharmacy Call Center is 1.866.270.3877 (TTY 711).

2.11.2 Coverage Determinations and Appeals

The SECUR Pharmacy Call Center maintains a toll-free call center to respond to provider requests for information related to coverage determinations, including exceptions, prior authorizations, and appeals.

The Pharmacy Call Center is available twenty-four (24) hours per day, seven (7) days a week, closed on Thanksgiving and Christmas Day.

- For coverage determination calls, resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests.
- For appeals calls, resolution within seventy-two (72) hours for expedited appeal requests and seven (7) calendar days for standard appeal requests.

These time limits are based upon receipt of all required information to complete the request.

Provider Manual

Section 3.0

SECUR Administrative Procedures

3.0 SECUR Administrative Procedures

SECUR is committed to providing participating entities with access to information, guidance, and resources necessary to support the delivery and coordination of services for SECUR members.

3.1 Members

Once the member has selected SECUR, the member will receive a welcome kit after CMS has accepted the enrollment application.

3.1.1 Member Identification Cards

SECUR will issue an identification card for each member. Members are always advised to keep their ID card with them and to present the card to their provider when services are rendered.

- ID cards contain the following information:
 - Member's name and date of birth
 - PCP name and telephone number
 - SECUR identification number
 - SECUR contact information
 - Claims filing address
 - Rx BIN and Rx PCN.

3.2 Choosing a Primary Care Provider (PCP)

Making sure members have selected a PCP is at the heart of SECUR's approach to managing the care of its member population. Members may choose a PCP from SECUR's Provider Directory when they enroll in a SECUR Medicare Plan. The PCPs, in their role, provide members with primary and preventive care and arrange for other medically necessary services for members. Therefore, SECUR acts quickly to make sure that members are linked to a PCP.

3.2.1 Assigning PCPs

- During enrollment, members are given the option of designating a PCP on the enrollment form. Members are encouraged to choose a PCP from the approved plan network during Open Enrollment with a SECUR sales agent.
 - SECUR will notify the member in writing of the member's PCP with a welcome letter and the provider's name on the identification card within two (2) weeks after CMS approves the application.
- SECUR will notify the PCP via the Provider Portal of any new members assigned to their panel monthly. Providers are encouraged to reach out to SECUR for assistance if they cannot access Provider Portal to view their member panel at any time.

3.2.2 Changing PCPs

Circumstances may arise that may necessitate the need for a member to change their PCP. Common scenarios may include, but are not limited to:

- Provider retiring from practice.
- Provider moving office locations outside of SECUR's service area.
- Provider voluntarily terminating its contract.
- Member electing to change PCPs.
- Member moving within the SECUR service area, but a significant commute from the PCP.

For all PCP activities that are impacted by a PCP no longer participating in the network, SECUR makes a good faith effort to provide a 30-day notification to all members assigned to that PCP. SECUR assists members in making a new PCP election. Additionally, a member may elect to change PCPs at their own discretion. Members can make the request by calling Member Services at 1.833.76SECUR (1.833.767.3287). A new ID card will be sent to the member reflecting the change in their PCP selection.

3.3 Acceptance of Members

Participating entities shall accept SECUR members who select or are assigned to them in accordance with the applicable agreement and SECUR policies, as applicable to the services furnished.

SECUR recognizes that certain participating entities may need to limit the acceptance of new members or service requests in order to maintain appropriate service capacity, quality, or regulatory compliance. Requests to limit acceptance of new members or services must be submitted in writing to SECUR with at least thirty (30) days' advance notice and are subject to SECUR's prior written approval. Requests must be submitted to Network Contracting at contracting@securhealthplan.com.

Upon SECUR's approval of a limitation, the participating entity must continue to furnish services to members who were accepted or assigned prior to the effective date of the limitation, unless otherwise permitted by SECUR or applicable law. Any limitation may apply only to new members or service requests and shall not adversely affect existing members.

If a member seeks to receive services from a participating entity that has limited acceptance to existing members or services, SECUR may contact the participating entity to verify eligibility

under the approved limitation. Upon confirmation, SECUR may allow the member to receive services in accordance with applicable policies.

Requests to remove or modify an approved limitation must be submitted in writing to SECUR and must include the requested effective date. Such requests are subject to SECUR's review and approval.

Once a participating entity accepts a member or furnishes services to a member, discontinuation of services may occur only in accordance with this Provider Manual, the applicable agreement, and all applicable federal and state laws and regulations.

3.3.1 Member Dismissal from PCP Panel

If a member is disruptive, abusive, or does not comply with the member's Rights and Responsibilities, as set forth herein, the provider and hospital may notify the member of the situation in writing. However, the provider and hospital may not terminate the member from their panel or services.

Provider and hospital must request to SECUR, in writing, that a member be removed from their panel; provided, however, that no such request can be based on the member's medical condition, which request shall be determined by SECUR in its sole discretion. Such requests and all supporting documentation must be sent to SECUR's network representative.

3.4 Verification of Eligibility

Member eligibility may change. Participating entities are responsible for verifying a member's eligibility with SECUR prior to furnishing services, as applicable to the services provided.

Before furnishing services, participating entities should take reasonable steps to verify eligibility, which may include the following:

- Request the member's SECUR identification card or other proof of enrollment.
- For an initial encounter, request additional personal identification, such as a government-issued photo ID, when appropriate.
- Verify eligibility through SECUR's Provider Portal at <https://um-secur.mirrahealthcare.com/>.
- Refer to current eligibility information available through SECUR systems or contact SECUR using the telephone number listed on the member's identification card to confirm enrollment status and plan type.

SECUR determines member eligibility for covered services and makes eligibility information available to participating entities upon request. SECUR shall issue identification cards to members that identify the individual as a SECUR member and include applicable plan information and a toll-free telephone number for eligibility verification or other inquiries.

SECUR will make reasonable efforts to confirm or deny eligibility using the most current information available. However, verification of eligibility by a participating entity or confirmation by SECUR does not guarantee member eligibility at the time services are rendered and does not constitute a guarantee of coverage or payment for any services furnished.

3.5 Timely Filing Requirements

Contracted (network) providers and hospitals must submit complete and accurate claims to SECUR within 120 calendar days of the date of service (DOS), unless otherwise specified in the provider agreement. Claims submitted after this period are considered untimely and will be denied. Timely filing requirements apply to all initial submissions and resubmissions unless a valid good-cause exception is documented in accordance with SECUR policy and applicable regulations.

Electronic Data Interchange (EDI) Rejections

Claims that fail electronic data interchange (EDI) validation are not accepted into SECUR's claims processing system and are therefore not considered received.

- Providers must correct and resubmit the rejected claim within sixty (60) calendar days from the date of the EDI rejection notice.
- Failure to correct and resubmit within the 60-day window may result in denial for untimely filing.

Corrected Claims

If a claim is denied due to missing, incomplete, or invalid information, providers may submit a corrected claim.

- Corrected claims may be submitted electronically or via paper within sixty (60) calendar days from the date of the denial or remittance advice.
- When submitting a corrected paper claim, providers must:
 - Clearly mark the claim as “CORRECTED.”
 - Identify and update the corrected fields.
 - Attach all relevant documentation supporting the revision.

Mailing Address for Corrected Paper Claims

Corrected paper claims must be claimed to:

SECUR Health Plan
 ATTN: Claims Department
 P.O. Box 3600
 Spring Hill, FL 34611

Requirements for Corrected Claims

A corrected claim must fully replace the original claim, not just the specific lines or fields being updated. The corrected submission should include:

- All claim lines from the original claim
- Any new or additional charges
- All corrected data elements
- Supporting documentation when applicable

Providers must use resubmission code “7” to indicate that the file is a replacement of a previously adjudicated claim.

Corrected claims must not include requests for reconsideration, disputes, or appeals. Appeals must be submitted through the formal claims dispute or reconsideration process as outlined in Section 3.16.

3.6 Procedures for Claim Submission

SECUR is committed to accurate, timely, and compliant processing of Medicare Advantage claims in accordance with CMS regulations. This section outlines the core operational components necessary for claims lifecycle management, provider responsibilities, and regulatory expectations.

Providers must submit claims electronically or on approved CMS forms (CMS-1500 for professional services, CMS-1450/UB-04 for institutional services). Electronic submission is preferred and must conform to HIPAA standards using ANSI X12 formats. Paper claims must be legible and contain complete and accurate data.

Required Claim Elements

Each claim submission must include:

- Member ID and full name
- Dates of service
- Place of service codes

- Accurate diagnosis (ICD-10-CM) and procedure codes (CPT/HCPCS)
- National Drug Code (NDC) when applicable
- Attending/rendering provider NPI
- Itemized charges and total billed amount

SECUR is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims. When required data elements are missing or invalid, claims will be rejected by SECUR. And the provider must correct and resubmit the claim as outlined in Section 3.5 of this manual. Claims filed with SECUR are subject to the following procedures:

- Verification that all required fields are completed on the appropriate forms: CMS-1500 for professional services, CMS-1450/UB-04 for institutional services.
- Electronic claims must be submitted via an ASC X12 837 professional claim file or ASC X12 837 institutional claim file meeting the 5010 HIPAA EDI standards.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of the referral for specialist or non-primary care physician claims.
- Verification of member eligibility for services under SECUR during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out-of-network” provider has received authorization to provide services to the eligible member (excluding “self-referral” types of care).
- Verification that an authorization has been given for services that require prior authorization by SECUR.
- Verification that the claim includes the appropriate NPI number and taxonomy code.

In addition, SECUR uses claim edit applications following NCCI, AMA, and CMS guidelines:

- Procedure unbundling (billing two or more CPT codes when one CPT code exists for same procedure).
- Incidental procedures (procedures performed at the same time as a more complex procedure but require little to no additional physician resources or are clinically integral to the performance of the procedure).
- Mutually exclusive procedures (two or more procedures that should not be performed or billed for the same member on the same date of service).
- Multiple surgical procedures (surgical procedures are ranked according to clinical intensity and are paid following percentage guidelines).
- Multiple Procedure Payment Reduction (MPPR) for selected therapies (applies to multiple procedures and multiple units).
- Duplicate procedures (procedures billed more than once on same date of service).
- Assistant surgeon utilization (reimbursement and coverage determination).
- Evaluation and management service billing (review the billing of services with procedures performed).
- ER evaluation and management services (review the billing for consistency with ACEP guidelines).
- Any CPT/HCPCS level 1 or 2 codes denied due to claims editing will be associated with the appropriate disposition code on the remittance advice.

Prior to submitting a claim, it is important to determine if any other payer has primary responsibility for payment of a claim. Referred to Coordination of Benefits (COB) and allows

plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan). The identification of the primary payer prior to claim submission will improve the efficiency and accuracy of the claim payment process. "Primary plan" means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration.

When Medicare Advantage members have other insurance, SECUR requires providers to bill the primary payer first. A copy of the primary Explanation of Benefits (EOB) must accompany the submission. Claims without proper coordination of benefits (COB) documentation may be denied.

Clean claims contain all required fields and supporting documentation. These are processed within thirty (30) calendar days of receipt. Non-clean claims (incomplete or incorrect) are returned for correction or denied. SECUR will identify deficiencies in the rejection or denial notice.

3.7 Rejected and Denied Claims

Claims may be rejected or denied depending on the issue identified during processing. Understanding the difference helps ensure timely resubmission and accurate payment.

Rejected Claims

A rejected claim is one that cannot be processed because required data is missing, invalid, or formatted incorrectly (for example, invalid member ID, missing NPI, incorrect taxonomy, or incomplete billing fields.)

- Rejected claims never enter SECUR's claims processing system and are therefore not considered received.
- Because they are not registered, rejected claims must be corrected and resubmitted within sixty (60) calendar days from the rejection date.
- This requirement applies to both electronic and paper submissions.

Timely corrections ensure your claims are accepted into the system and avoid unnecessary timely filing denials.

Denied Claims

A denied claim is one that has been received and processed but does not meet the requirements for payment under SECUR's policies, contract terms, or applicable Medicare rules.

Common reasons for denials include:

- Missing or invalid documentation
- Lack of required authorization
- Non-covered services
- Provider not contracted for the billed service

Providers may correct and resubmit denied claims within sixty (60) calendar days from the date of the denial.

- Corrected denials must be submitted electronically or on paper.
- When resubmitting a corrected claim, providers must use frequency code “7” to indicate that the claim is a replacement of the prior submission.

Please note: Requests for reconsideration or appeals must be submitted through SECUR’s Claims Dispute process, not as a corrected claims.)

3.8 Interest on Late Payment of Clean Claims

For clean claims that are processed after the 30-calendar day prompt pay period, SECUR will pay interest as determined by the applicable rate on the day of payment as established by the United States Secretary of the Treasury, as published in the Federal Register. The amount of interest is reported on the remittance advice to the provider.

3.9 Claim Mailing Instructions

SECUR encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor Provider Support Line at to arrange transmission.

SECUR Electronic Payer ID: SECUR

If you choose to utilize paper claims, please submit to SECUR at the following address:

SECUR Health Plan
ATTN: Claims Department
P.O. Box 3600
Spring Hill, FL 34611

3.10 Claims Status Review

Providers may review the status of submitted claims using the following methods:

Online Portal (Preferred Method)

Check eligibility and claims status by logging into SECUR’s Provider Portal at:

<https://um-secur.mirrahealthcare.com>.

The portal provides real-time claim updates, payment details, and remittance information.

Email

Providers may submit claim status inquiries to:

claims@securhealthplan.com.

All claim-related inquiries must include:

- Claim number
- Date of service
- Member name and SECUR member ID number

Providing complete information ensures timely and accurate processing of your request.

3.11 Notification of Denial via Remittance Advice

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or a corrected claim, and resubmitted within sixty (60) calendar days of notification of payment/denial either electronically or to the general claim address. Contracted providers receive remittance advice directly from SECUR's delegated claims adjudicator. See Section 3.17 of this Provider Manual for information on non-contracted providers' remittance advice procedures.

3.12 Claim Forms and Field Requirements

To ensure accurate and timely processing of claims, providers must complete all required fields on the appropriate CMS claims form. Claims that are missing mandatory information or contain invalid data may be rejected or denied and must be corrected and resubmitted in accordance with SECUR's timely filing requirements.

CMS Standard Claim Forms

CMS-1500 (Professional Claims)

The CMS-1500 form must be used for all professional medical services, including services rendered by physicians and other non-facility providers.

CMS-1450/UB-04 (Facility Claims)

The CMS-1450 (formerly UB-04) form must be used for all facility-base services, such as those billed by hospitals, skilled nursing facilities, ambulatory centers, and other institutional providers.

All claims must be submitted within the timeframe specified in the provider agreement and outlines in Section 3.5 Timely Filing Requirements.

Required and Conditional Fields

Each claim form contains data fields that may be designated as:

- **Required (R):** The field must be completed for all claims without exception.
- **Conditional (C):** The field must be completed only when certain circumstances apply. The conditions and instructions for these fields are provided in industry-standard billing guides (CMS-1500 and UB-04 manuals) and in SECUR's billing requirements.

Providers are responsible for ensuring that all required (R) fields are accurately completed and that all conditional (C) fields are completed when applicable.

Examples include, but are not limited to:

- **Member information:** Name, date of birth, ID number
- **Provider identifiers:** NPI, taxonomy codes, service location
- **Claim details:** Dates of service, place of service, procedure, and diagnosis codes
- **Payment information:** Prior authorization numbers (when required), modifiers, billed charges

Incomplete, inaccurate, or improperly formatted fields may cause the claim to be rejected before entering the claims processing system.

Provider Responsibilities

To ensure successful claim submission:

- Use only the correct CMS-1500 or CMS-1450 claim format
- Complete all required and applicable conditional fields
- Ensure all diagnostic and procedure codes are valid for the date of service
- Attach supporting documentation when required for specific claim types
- Submit claims within the specified timely filing period
- Confirm that claims adhere to HIPAA, CMS, AMA, and NCCI billing standards

Adherence to these requirements reduces processing delays, minimizes rework, and supports timely and accurate payment.

3.13 Procedures for Electronic Submission

EDI allows for faster, more efficient, and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs. The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

3.14 Requirements for Electronic Claim Filing

The following sections describe the procedures for electronic submission for hospital and medical claims, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

3.14.1 Hardware/Software Requirements

Providers may use different products to bill electronically. Providers may submit claims electronically if their software has the capability to send EDI claims to Waystar, Change Healthcare, Availity, or through either direct submission or through another clearinghouse /vendor.

Waystar, Change Healthcare, and Availity have the capability to accept electronic data from numerous providers in several standardized EDI formats. Waystar, Change Healthcare, and Availity forward the accepted information to carriers in an agreed upon format.

3.14.2 Contracting with Electronic Vendors

Providers without Waystar, Change Healthcare, or Availity EDI capabilities who are interested in electronic claims submission may contact these clearinghouse vendors to arrange for the ability to submit claims electronically. Providers may also choose to contract with another EDI clearinghouse or vendor who already has EDI capabilities.

After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or EDI vendor to initiate electronic submissions to SECUR. (SECUR's electronic payer identification number is SECUR).

3.14.3 Plan-Specific Electronic Edit Requirements

SECUR claims and encounters may be submitted electronically or on paper. SECUR paper claims and encounters should be mailed to:

SECUR Health Plan
ATTN: Claims Department
P.O. Box 3600
Spring Hill, FL 34611

3.15 Encounter Data

As required by SECUR and applicable law, providers submit complete and accurate encounter data to SECUR daily or no less frequently than monthly. All data must be submitted by the last calendar day of each month for encounters from the preceding month. SECUR may require more frequent submission as needed by regulatory obligations.

Encounter data must be submitted on the CMS-1500 (professional claims), CMS-1450/UB-04 (institutional claims), or electronically in a format defined by SECUR. Providers are required to certify the accuracy, completeness, and truthfulness of all data submissions in accordance with SECUR policy and applicable law.

Failure to submit encounter data as required may result in payment withholding or a determination of material breach of contract at SECUR's sole discretion.

3.15.1 Provider's Role in Risk Adjustment

Encounter data drives risk adjustment for Medicare Advantage members. Provider compliance with encounter data submission directly impacts member risk scores and CMS revenue integrity.

Each primary care provider (PCP) office must designate an encounter data coordinator responsible for timely and complete submission. Providers must:

- Submit data for each member visit.
- Use current, HIPAA-compliant ICD-10, CPT, HCPCS, DRG, and revenue codes.
- Report all diagnoses from a face-to-face visit, including those related to quality measures.
- Code to the highest specificity, including 3rd, 4th, and 5th digits.
- Document all conditions affecting care.
- Continuously report chronic conditions under treatment.
- Retain full documentation for audit readiness.

3.16 Claims Disputes

Contracted providers may dispute a denied claim by submitting a formal written request with supporting documentation within sixty-five (65) calendar days of denial. Disputes must be submitted securely to:

SECUR Health Plan
Attn: Claim Payment Disputes
12470 Telecom Drive, Suite 301
Temple Terrace, FL 33637
Grievanceandappeals@securhealthplan.com

3.17 Non-Contracted Providers

3.17.1 Claims Submission

Non-contracted providers must follow Original Medicare timely filing rules. Claims (or corrected claims) must be submitted within 365 days from the date of service. Claims submitted beyond this threshold will be denied.

3.17.2 Exceptions to Timely Filing Limitation

Non-contracted providers may submit claims beyond the 365-day deadline under the following exceptions:

3.17.2.1 Administrative Error

An error or misrepresentation by SECUR or CMS. Filing is extended 180 days from notification of correction.

3.17.2.2 Retroactive Medicare Entitlement

Filing is extended 180 days from notification of retroactive Medicare coverage.

3.17.2.3 Retroactive Medicare Entitlement Involving State Medicaid Agencies

If Medicaid recoups funds due to Medicare retroactively, providers may file to SECUR within 180 days of the Medicaid recoupment.

3.17.2.4 Retroactive Disenrollment from SECUR's Medicare Advantage Plan

If a member is retroactively disenrolled and SECUR recoups payments, providers may file Original Medicare within 180 days from the recoupment date.

3.17.3 Payments

Non-contract providers must accept Medicare fee schedule rates. A waiver of liability (WOL) form must be submitted within sixty (60) calendar days for payment. Balance billing members is strictly prohibited.

3.17.4 Referrals to Non-Contracted Providers

If a SECUR contracted provider refers a member to a non-contracted provider, it is considered plan-directed care and must be processed as in-network. The member is responsible only for in-network cost sharing.

3.17.5 Services Covered Out of Network

SECUR covers the following out-of-network services:

- Emergency and urgent care services
- Ambulance transport dispatched through 911
- Maintenance/post-stabilization care
- Medically necessary dialysis when the member is temporarily out of SECUR's service area.
- Reversed denials on appeal
- Specialty care required outside of SECUR's network

3.17.6 Claim Development of Non-Clean, Non-Contracted Provider Claims

SECUR will deny incomplete claims from non-contracted providers within sixty (60) days if additional information is not received.

3.17.7 Balance Billing

Balance billing by contracted providers is prohibited. SECUR is financially responsible for covered services. If a member pays a balance-billed invoice, SECUR will reimburse the member and require the provider to submit a claim.

3.17.7.1 Medicare Participating Providers

SECUR reimburses the difference between the member's cost-sharing and the Medicare limiting charge.

3.17.7.2 Non-contracted, non-Medicare Participating Providers

Same as above — SECUR pays up to the Medicare limiting charge.

3.17.8 Claims Denial, Notification, and Appeal Rights

Non-contracted providers have the right to appeal full claims denials. Appeals must include the following: original claim or denial notice, clinical. See Appendix 3 of this manual for a sample of the waiver of liability (WOL) form.

Appeals must be submitted within sixty-five (65) calendar days of denial.

3.18 Claims Reconciliations (50+ Claims)

Providers and facilities that have 50 or more disputed claims may request a bulk claims reconciliation through SECUR's Claims Reconciliation Unit. This process allows SECUR to review multiple disputed claims at once and streamline resolution.

How to Submit a Bulk Reconciliation Request

To initiate a bulk review, providers must prepare an Excel spreadsheet containing the required details for each disputed claim. The spreadsheet must include the following:

Header Information

- Provider/Facility Name
- D/b/a name, if applicable
- Tax identification number (TIN)

Required Columns

- SECUR Provider ID Number
- Member ID
- Member First and Last Name
- Dates of Service
- Billed Charges
- Outstanding Balance
- Claim Number, if available
- Authorization Number
- Authorization Issue (e.g., number of days or description)
- Account Number
- Comments/Notes

Submitting the Spreadsheet

- The spreadsheet must be password-protected to ensure HIPAA compliance.
- Email the password-protected file to: claims@securhealthplan.com.
- Send the password in a separate email for security purposes.

SECUR Review and Response Time

The Claims Reconciliation Unit will complete its review and provide a response to the provider or facility within forty-five (45) calendar days of receiving the complete and accurate spreadsheet.

3.19 Overpayment Recoveries

If SECUR identifies that a claim has been overpaid, the provider or facility will receive a written notification of overpayment amount being recovered. Overpayment notices outline the reason for the overpayment, the amount owed, and instructions for next steps. This process complies with all applicable federal and state laws.

Providers with questions regarding an overpayment notice or any explanation of payment (EOP) entry that reflects a negative balance may contact SCUR at: claims@securhealthplan.com.

Providers and facilities are required to address and resolve all overpayments in accordance with applicable laws, regulations, and the SECUR provider agreement.

3.19.1 Self-Identified Overpayment

Providers are required to submit all provider-initiated overpayment recoveries directly to SECUR. Refund submissions must include supporting claim details and be mailed to:

ATTN: SECUR Health Plan Account Payable
12470 Telecom Drive, Suite 310
Temple Terrace, FL 33637

All submissions must include:

- Claim number
- Member name and Member ID
- Dates of service
- Reason for the overpayment/refund

Once received, SECUR will process the recovery, adjust the applicable claim(s), and reflect the transaction on the provider's remittance advice.

3.19.2 Provider Dispute or Appeal of Overpayment

If a provider disagrees with SECUR's overpayment determination, the provider must submit a dispute or appeal within forty-five (45) calendar days from the date of the explanation of payment (EOP). Any submissions after the 45-day timeframe may be denied as untimely in accordance with applicable regulatory requirements.

Upon receipt of a provider's dispute or appeal:

- SECUR will document the overpayment recovery in its tracking system in compliance with NCQA and Medicare Advantage standards.
- Recovery efforts will be suspended while the dispute or appeal is under review.
- SECUR will review, monitor, and process the dispute or appeal in alignment with established internal procedures, contractual obligations, and all applicable federal, state, and Medicare Advantage regulations.

A written outcome will be provided upon completion of the review.

3.20 Capitation

SECUR issues monthly capitation payments to providers who are contracted under a per member, per month (PMPM) reimbursement arrangement. Capitation payments are processed once each month, and capitated providers will receive payment on or about the 20th of each month, unless otherwise specified in the agreement.

A detailed report outlining the capitation calculation, covered members, and payment details is provided with each monthly payment. Providers should review this report carefully to ensure all data is accurate.

If you have questions regarding your capitation payment or require clarification about your capitation report, please contact SECUR Claims Department at: claims@securhealthplan.com.

3.21 Risk Adjustment

CMS is required by law to adjust payments to Medicare Advantage (MA) organizations based on the health status of Medicare members. Risk adjustment is used to align payments made to SECUR by CMS based on the health status and demographic characteristics of a member. CMS requires SECUR to submit diagnosis data including physician, inpatient, and outpatient facility encounters. Therefore, providers are required to submit accurate and complete diagnosis information to SECUR.

Medicare Advantage members are classified into diagnostic cost groups, using the hierarchical condition category (HCC) payment model, which applies the diagnosis codes reported by the Physician to determine the risk-adjustment factor (RAF) for each member. The cost groups identify those members with chronic conditions, such as diabetes or congestive heart failure, which are often the most expensive to treat.

3.21.1 Risk Management Department

The Risk Management Department at SECUR works closely with providers to support accurate documentation of conditions used for risk scores, quality initiatives, case management, and disease management. The department reviews and analyzes data internally and perform periodic site visits to review medical records to help determine the needs of each provider's office. The department assists the provider with coding education and appropriate submission of data, so that each Medicare member's risk score is accurately captured. In addition, SECUR will assist offices in ensuring that all CMS guidelines are followed as they relate to Medicare Risk. For questions, further information, or assistance with Medicare Risk, call the Risk Management Department at 1.833.76SECUR (1.833.767.3287).

3.22 Glossary of Claims Terms

ANSI X12:

A standardized electronic data interchange (EDI) format used for transmitting health care claims and related transactions.

Authorization (Prior Authorization):

Approval required from SECUR before certain services or prescriptions are rendered, ensuring medical necessity and benefit coverage.

Bundling:

A billing error in which multiple services are incorrectly combined into a single charge when separate reimbursement is required.

Clean Claim:

A claim that contains all required information and documentation, submitted correctly the first time and ready for processing without the need for additional information.

CMS (Centers for Medicare & Medicaid Services):

The federal agency that administers the nation's major healthcare programs including Medicare and enforces compliance with regulations.

COB (Coordination of Benefits):

A process that ensures a claim is processed in the correct order when a member has more than one insurance plan.

Corrected Claim:

A resubmission of a previously processed claim with corrections. It must include the original claim number and appropriate frequency code.

CPT (Current Procedural Terminology):

A set of medical codes used to report diagnostic, surgical, and medical services.

Denial:

A claim that is rejected for payment due to issues such as missing documentation, eligibility problems, or lack of authorization.

EOB (Explanation of Benefits):

A statement from a health insurance company that explains what medical treatments and/or services were paid for, denied, or applied to deductible.

Encounter Data:

Detailed records of patient interactions, used to reflect the clinical experience and drive risk adjustment and quality metrics.

Frequency Code:

A code used on institutional and professional claim forms to indicate whether the claim is an original, corrected, or voided submission.

HCPCS (Healthcare Common Procedure Coding System):

A coding system used for billing Medicare and identifying services, equipment, and supplies not included in the CPT system.

HIPAA (Health Insurance Portability and Accountability Act):

A federal law that includes standards for protecting patient health information and facilitating electronic healthcare transactions.

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification):

A medical classification system for diagnosis coding used in billing and documentation.

NDC (National Drug Code):

A unique 10-digit number identifying pharmaceuticals by manufacturer, product, and package size.

NPI (National Provider Identifier):

A unique identification number assigned to healthcare providers for use in billing and administration.

RA (Remittance Advice):

A document issued by the payer explaining payment or denial decisions made on submitted claims.

Retroactive Eligibility:

A CMS-recognized change in a member's eligibility that applies to past dates of service, which may allow claim reconsideration.

Risk Adjustment:

A CMS process that adjusts payments to health plans based on the health status and demographic characteristics of enrollees.

SHP (SECUR Health Plan):

The Medicare Advantage health plan referenced throughout this manual.

Timely Filing:

The maximum time period from the date of service in which a provider must submit a claim for it to be eligible for payment.

Rejection:

A claim that is returned to the provider without being registered in the claims processing

system due to invalid or missing information. Rejected claims must be corrected and resubmitted within the timely filing limits.

Unclean Claim:

A claim that is incomplete, contains errors, or lacks required documentation, resulting in a rejection or denial. These claims require correction and resubmission before processing can occur.

Provider Manual

Section 4.0

Credentialing

4.0 Credentialing Overview

SECUR through its parent – CareNu, is a NCQA-accredited Credentialing Verification Organization and complies with state and federal credentialing requirements that require that providers be credentialed. All physicians, hospitals, ambulatory surgery centers (ASCs), skilled nursing facilities (SNFs), and allied health professionals must be credentialed by SECUR, or an approved delegate of SECUR.

Initial credentialing applications will be given to providers and hospitals by the network representative. Primary source verification will be completed for information reported on the application. In addition, SECUR will query the National Practitioner Data Bank, the Florida Department of Health, and other databases and sources to obtain information about the applicant.

Providers and hospitals shall, and shall cause provider staff or hospital vendors, as applicable, to comply with SECUR's credentialing criteria by providing a completed credentialing application and such additional information concerning providers and/or provider staff, hospitals and/or hospital vendors as follows:

- Licensure
- Education
- Experience
- Training
- References
- Malpractice liability insurance
- Hospital staff status
- Hospital clinical privileges
- Hospital staff reappointment dates
- Eligibility for payment under Medicare
- Exclusion from or voluntarily opted out of the Medicare program
- Disciplinary status
- Any other information, as SECUR may request from time to time, which is on its forms, executed, dated, and includes an attestation by the hospital, provider, provider staff, or hospital vendors, as applicable, of the correctness and completeness of the application and other information submitted in support of the application.

Hospitals and providers authorize SECUR to query the National Practitioner Databank and all other authorities with information regarding provider or hospital. Providers and hospitals shall cause provider staff and hospital vendors, as applicable, to notify SECUR within ten (10) days of any change in the information provided to SECUR in their credentialing or recredentialing application, or any information submitted in support of such applications. All credentialing and recredentialing applications shall be incorporated into the agreement.

SECUR's Credentialing Committee renders decisions on whether to grant or deny credentialing to the provider or hospital. Credentialing is granted for a three-year period. However, the committee may choose to grant credentialing for a lesser time limit.

A credentials file is maintained on each provider and hospital. SECUR maintains credentialing files and supports electronic systems in a confidential manner and uses all information collected solely for the purpose of credentialing. Credentialing decisions are made by SECUR's Credentialing Committee and applicants are notified of committee decisions by letter. The Credentialing Committee meeting minutes and discussions are confidential.

4.1 Credentialing Requirements

The following information is considered by SECUR's Credentialing Committee, in addition to CVO all requirements and applicable federal and state law. SECUR's verification time limits for:

- Licensure, DEA license, or CDS certificate, Board certification and professional liability claims is 180 calendar days from submission of a clean application.
- Work history is 365 calendar days from submission of a clean application.
- Education is prior to the credentialing decision being made.

Consideration of the following information may change based on applicable accreditation and regulatory requirements:

- Physicians (MD, DO, DC, DMD/DDS, DPM, etc.)
 - Updates CAQH
 - Complete/signed Credentialing Application
 - Valid, current medical license
 - Status of hospital privileges
 - Valid, current DEA license (if applicable) (or Controlled Dangerous Substances (CDS) certificate, if applicable)
 - Current Medicare Payor ID and minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five years
 - Board certification
 - Proof of education and training
 - Work history
 - Professional Malpractice Insurance (\$1M/\$3M required).
 - Professional malpractice history
- Other Providers (ARNP, PA, etc.)
 - Complete/signed Credentialing Application
 - Valid, current state license
 - Board Certificate (if applicable)
 - Valid, current DEA license (if applicable; or CDS certificate)
 - Current Medicare Payor ID and minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five years, if appropriate
 - Proof of education and training
 - Work history
 - Professional malpractice insurance (\$1M/\$3M required)
 - Professional malpractice history

- Facilities (Hospitals: Acute Care, Rehabilitation)
 - Complete/signed Facility Credentialing Application
 - Copy of current state license, pharmacy license, DEA registration (if applicable), and Medicare Payor ID
 - Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Accreditation or a State of Florida Site Survey filed with AHCA
 - Professional malpractice insurance (\$1M/\$3M required) or self-funded or Sovereign Immunity
 - Minimum of “Standard” Medicare rating with no suspensions or exclusions in the last five years
 - Florida license (active and free of current sanctions, suspensions, or revocations)

- Facilities (Ambulatory Surgery Centers, Invasive Diagnostic, etc.)
 - Complete/signed Facility Credentialing Application
 - Copy of current state license and Medicare Payor ID
 - Accreditation, or application for accreditation with AHCA or OSHA site survey
 - Professional malpractice insurance (\$1M/\$3M required)
 - Minimum of “Standard” Medicare rating (with no suspensions or exclusions in the last five years)
 - Florida license (active and free of current sanctions, suspensions, or revocations)

- Facilities (*Other*)
 - Complete/signed Facility Credentialing Application
 - Copy of current state license and Medicare Payor ID
 - If applicable, accreditation or application for accreditation with AHCA or OSHA site
 - Survey
 - Professional malpractice insurance
 - Minimum of “Standard” Medicare rating with no suspensions or exclusions in the last five (5) years
 - Florida license (active and free of current sanctions, suspensions, or revocations)

4.2 Recredentialing

Providers and hospitals shall cause provider staff and hospital vendors, as applicable, to cooperate with SECUR’s recredentialing process that is conducted at least every three (3) years or when their credentialing cycle expires, as required pursuant to applicable accreditation and regulatory requirements. SECUR may conduct site visits in connection with its credentialing and recredentialing processes, and provider and hospital shall fully cooperate with all SECUR personnel conducting such visits.

SECUR utilizes the Universal Credentialing DataSource developed by the Council for Affordable Quality Healthcare (CAQH) for the recredentialing purposes. The recredentialing application is available six (6) months prior to the recredentialing due date. Completed recredentialing packets are due within 30 days. Providers are responsible for ensuring their information is up to date in the CAQH system. If the information is not current upon recredentialing SECUR will notify the provider of the missing documentation via a second request notice, accompanied by a new

attestation. If the information is not returned within 30 days of the second notice, SECUR will send a third and final notice from SECUR's chief medical officer to the provider or hospital. The final notice will be sent via certified, registered mail, and will state the date of expiry of the current credentialing application and serves as a notice of termination from the network on the final day of that month.

Provider and hospital must complete the credentialing process and be approved by the Credentialing Committee. All providers and hospitals will be notified by letter of the Credentialing Committee's decision.

Recredentialing applicants will be contacted by SECUR's Credentialing Department if the application is not complete. Every effort should be made to provide missing information promptly.

SECUR will consider complaints and grievances regarding the provider or hospital at the time of recredentialing.

Providers and hospitals that fail to complete the recredentialing process or are denied recredentialing status on SECUR's network of providers and are no longer eligible to see members. However, if the provider or hospital acts within 30 days of expiration of the current credentialing application by providing the full recredentialing application, attestation, and requests reinstatement, SECUR may reinstate the provider or hospital without having to perform a full, initial credentialing process.

4.3 Keeping Credentialing Files Current

Time-sensitive documents must be kept current in the CAQH system. This includes medical license, DEA license, other state licenses, board certificates, and proof of malpractice insurance.

4.4 Mid-Cycle Reviews

SECUR will routinely monitor providers and hospitals to ensure any changes in licensure status, sanctions, or other adverse actions are reviewed by the Credentialing Committee. Providers or hospitals whose license was suspended or revoked are subject to termination by SECUR.

All providers and hospitals are required to report any adverse action taken by governmental, licensing, judicial, or other agencies. Such actions must be reported directly to SECUR Health Plan's network management, or the provider and hospital may mail documentation of adverse action to:

SECUR Health Plan
ATTN: Credentialing
12470 Telecom Drive, Suite 301
Temple Terrace, FL 33637
Email: credentialing@securhealthplan.com

4.5 Corrective Action

In the event a provider, hospital, provider staff, or a hospital vendor fails to comply with SECUR's Credentialing Criteria or with any corrective action plan imposed on them as a result of SECUR's credentialing or recredentialing activities, they shall be subject to any and all

enforcement actions imposed on such individual or entity by SECUR in accordance with this manual as otherwise permitted under the agreement or pursuant to all applicable laws and regulations. Neither provider, hospital, hospital vendors, nor provider staff shall provide any services to any member and SECUR shall have no obligation to pay for any services provided to a member prior to the effective date or the approval of their credentialing application by SECUR. In the event the provider, hospital, hospital vendor, or provider staff provides any service to any member prior to the effective date or the approval of their credentialing application, SECUR shall have the right to automatically deny their credentialing application and terminate the agreement.

4.6 Board Certification

SECUR requires contracted physicians to be board certified or board eligible. However, exceptions will be evaluated on a case-by-case basis. Considerations include, but are not limited to, physicians serving communities in which a special requirement is identified and where the population is otherwise underserved by SECUR-contracted physicians.

4.7 Credentialing Dual Specialties

Physicians who are board certified and participate as a PCP and who practice in subspecialties, such as Cardiology, Gastroenterology, Pulmonary Medicine, Hematology/Oncology, Allergy/Immunology, etc., must elect to participate as either a PCP or a Specialist.

Participation in two subspecialties is prohibited without prior approval of SECUR's Chief Medical Officer. Physicians requesting such an exception must submit documentation to support training and experience in the subspecialty and be approved by SECUR's Credentialing Committee.

Specialists who are board certified and are practicing in sub-specialties must be credentialed for each sub-specialty. At the time of initial credentialing, all training and experience will be reviewed and considered by SECUR's Credentialing Committee. If sub-specialties are added after initial credentialing, a new agreement and credentialing application must be completed, and documentation submitted to support the sub-specialty being added.

Provider Manual

Section 5.0

Physicians

5.0 Physicians

5.1 Primary Care Physicians

Primary Care Physicians (PCPs) are responsible for coordinating and managing the healthcare of members assigned to them in accordance with the applicable SECUR Medicare Plan, this Provider Manual, SECUR policies and procedures, and the applicable Provider Agreement. PCPs serve as the primary point of care for assigned members and coordinate all covered services, including specialty and other medically necessary services.

A participating PCP is a general or family practitioner, internist, or other provider furnishing primary care and member management services. PCPs must maintain admitting privileges at a participating hospital or have a formal referral arrangement with a provider who has admitting privileges, as required under the applicable agreement. PCPs must maintain arrangements to ensure members have access to care twenty-four (24) hours per day, seven (7) days per week, in accordance with SECUR policies.

PCPs are responsible for providing appropriate and adequate medical care to SECUR members. No action or determination by SECUR, or any entity acting on SECUR's behalf, relieves or limits the PCP's professional responsibility to furnish care consistent with applicable law and professionally recognized standards. SECUR recognizes and affirms that PCPs may freely communicate with members regarding diagnosis, treatment options, and non-treatment alternatives, regardless of whether such options are covered services, and nothing in this manual restricts open clinical dialogue between the PCP and the member.

SECUR may monitor PCP performance to ensure compliance with this manual, SECUR policies, and the applicable provider agreement. PCP responsibilities include, but are not limited to, the following:

- Maintaining continuity of care for assigned members.
- Coordinating and arranging medically necessary covered services, including specialty care and inpatient services, in accordance with SECUR policies.
- Coordinating care both in network and, when necessary, out of network, when covered services are not available within the SECUR network.
- Maintaining accurate, complete, and current medical records documenting all services rendered, including preventive, well-care, and specialty services.
- Providing or supporting initial assessments of newly assigned members, including health risk assessments, as required by SECUR policies and applicable CMS requirements.
- Providing preventive care and arranging for recommended screenings and services in accordance with SECUR Preventive Health Guidelines.

- Conducting screening and evaluation for known or suspected behavioral health conditions and arranging referrals when clinically appropriate.
- Providing or arranging access to behavioral health services in accordance with SECUR policies.
- Providing routine immunizations and injections, as applicable.
- Ensuring access to care after normal office hours through on-call coverage or other arrangements consistent with SECUR requirements.
- Arranging and providing necessary inpatient medical care at participating hospitals.
- Providing health education and information to members.
- Discussing advance directives with members, as appropriate, in accordance with applicable law and SECUR policies.
- Cooperating with SECUR in quality improvement, utilization management, audit, grievance, and appeal activities, including timely submission of medical records and clinical information when requested.
- Continuing care in progress for assigned members through the effective date of termination, in accordance with applicable law and SECUR policies.

PCPs are responsible for managing the care of their assigned SECUR members and directing members to specialty or other services when medically necessary and consistent with SECUR requirements.

5.2 PCPs Panel

PCPs may access current member assignment and eligibility information through SECUR's Provider Portal at <https://pm-secur.mirrahealthcare.com> or by contacting SECUR Member Services.

Member eligibility is subject to change, including retroactive termination by CMS. In such instances, and as permitted by applicable law and the provider agreement, SECUR may recoup payments made for services rendered to members who are later determined to be ineligible.

PCPs are expected to make reasonable efforts to contact newly assigned members to offer assistance and, when appropriate, to schedule an initial or follow-up office visit to support continuity of care.

Each PCP practice shall designate an individual responsible for coordinating prior authorization requests and ensuring that required documentation is submitted to SECUR in accordance with applicable policies and procedures.

5.2.1 Member Reassignment to New PCP Panel

PCPs are allowed to request that SECUR reassign a current patient to another network PCP based on the member's specific needs or behavior that requires special handling. Examples of appropriate reasons for reassignment include:

- Frequent missed appointments.
- Member fraud.

- Abuse, threatening, or hostile actions by the member.
- Special medical needs.
- Breakdown of the PCP-patient relationship.
- Member is accessing primary care from a provider other than the assigned PCP.
- A previously approved reassignment that was inadvertently overwritten through the auto-assignment process.

5.3 Directing Members to Appropriate Place of Care

When a member contacts the PCP's office prior to seeking care in a hospital emergency room, and the member's condition can be appropriately addressed in the PCP setting, the PCP is responsible for providing access to care in accordance with SECUR's access standards.

A referral or prior authorization is not required for a member to receive emergency services. PCPs are required, pursuant to their agreement with SECUR, to maintain arrangements for after-hours access to care twenty-four (24) hours per day, seven (7) days per week.

PCPs are encouraged to educate members during routine office visits regarding appropriate use of care settings, including when to seek urgent or emergency care and when conditions may be appropriately managed in an office or other non-emergency setting. Providing clear verbal or written guidance may help support appropriate utilization and continuity of care.

5.4 Plan-Directed Care

Plan-directed care refers to services that a member reasonably believes were directed, arranged, or authorized by SECUR or by a SECUR-contracted provider or entity.

In accordance with CMS requirements, covered services furnished as plan-directed care must be processed as in-network, and members are responsible only for the applicable in-network cost sharing. Members may not be penalized or held financially liable due to a provider's failure to follow SECUR administrative requirements, including referral or authorization procedures.

This requirement does not apply to items or services that are expressly excluded from coverage under the applicable Evidence of Coverage or when the member has received advance written notice of an adverse coverage determination.

If a provider or entity believes that an item or service may not be covered, or may be covered only under specific conditions, the appropriate course of action is to request a preservice organization determination from SECUR prior to furnishing or referring the service.

When a SECUR-contracted provider or entity refers a member to a non-contracted provider for a covered service, the member's financial liability is limited to the applicable in-network cost sharing. Contracted providers and entities are expected to coordinate with SECUR, including obtaining required authorization when applicable, prior to referring members to non-contracted providers to support appropriate utilization, coverage determination, and continuity of care.

5.5 Coordinated Care and Prior Authorizations

Under specified SECUR Medicare Plans, prior authorization may be required for the member to obtain specific care from a specialist, ancillary provider, hospital, and other healthcare

provider. These providers are listed in the SECUR Provider Directory, which is made available to PCP at the time of contracting with SECUR. To obtain a copy of the Provider Directory, contact Member Services. See the SECUR contact information section in this manual for phone numbers. A prior authorization may be completed on a paper form (see the forms section of this manual) or electronically, based on your office's capability. SECUR has also provided a sample prior authorization form on the SECUR website at <https://securhealthplan.com/provider-resources/>.

Any laboratory services provided to members in the providers' office shall not be reimbursable covered services, unless otherwise expressly provided in the agreement.

Prior requirements are in Section 7.5 of this manual.

5.5.1 Initiating a Prior Authorization

A sample prior authorization form can be located at www.securhealthplan.com/provider-resources. Referrals are not required. However, providers may use their existing office referral forms and process to communicate with the specialist office.

Distribution of forms is based on the selected method and detailed below:

5.6 Participating Providers

All coordinated care shall be directed by participating providers in accordance with this Provider Manual.

5.7 Specialist Physicians

Specialist physicians are responsible for furnishing specialty services and coordinating care with the member's Primary Care Physician (PCP), as applicable. The specialist and the PCP work collaboratively to support the member's medical care and continuity of services.

Specialty services should be coordinated through the PCP when required by the applicable SECUR Medicare Plan. Specialists must obtain any required prior authorization for hospital admissions or specified diagnostic or therapeutic procedures. Refer to Section 7.5 Authorization Requirements for a complete list of services requiring prior authorization from SECUR's Utilization Management department.

5.8 Specialist Services

Specialists are expected to communicate regularly with the member's PCP or other applicable network provider regarding specialty treatment and outcomes. Specialists must report the results of services rendered and provide relevant clinical findings, test results, and recommendations to the PCP in a timely manner, consistent with standard professional practice.

5.9 Follow-Up Care

Physicians and SECUR-contracted specialists must promptly and openly communicate with the member's PCP regarding the member's medical condition, including the need for additional or follow-up covered services.

When follow-up services require prior authorization, the specialist or treating provider is responsible for ensuring that the appropriate prior authorization is obtained in accordance with SECUR's Utilization Management requirements prior to furnishing such services.

5.10 Advance Directives

SECUR recognizes each member's right to make decisions regarding future healthcare, including the right to execute or refuse an Advance Directive, in accordance with applicable state and federal law.

Advance Directives are written instructions, recognized under state law, that describe a member's wishes concerning healthcare decisions if the member becomes unable to make or communicate those decisions. In Florida, Advance Directives include, but are not limited to, a Designation of Health Care Surrogate and a Living Will.

Providers and hospitals must comply with all applicable federal and state laws and regulations governing Advance Directives and must document, in a prominent part of the member's medical record, whether the member has executed or declined to execute an Advance Directive. Providers and Hospitals may certify if they are unable to implement an Advance Directive on grounds of conscience, as permitted by applicable state law, and must communicate such objections to the member.

Florida Advance Directive forms are available through the National Hospice and Palliative Care Organization's Caring Connections website at www.caringinfo.org.

5.11 Hospital Care

Providers must have admitting privileges to SECUR's network hospital or facility for all patient groups for whom they are providing care to. A provider may arrange for another participating provider to provide inpatient coverage.

Provider Manual

Section 6.0

Medical Records

6.0 Medical Records

6.1 General Medical Records Guidelines

Providers and hospitals shall prepare and maintain complete medical records for members under their care in a manner that complies with the following:

- Applicable federal and state laws, licensing, accreditation, and reimbursement rules and regulations applicable to SECUR and accepted medical practice.
- In accordance with federal and state law and the agreement, each provider and hospital must protect the confidentiality of members' patient records. To fulfill this obligation, providers and hospitals must designate a person in charge of the providers' or hospital's medical records, and such person's responsibilities include, but are not limited to, the following duties in accordance with federal and state law and the agreement:
 1. Maintaining the confidentiality, security, and physical safety of patient records.
 2. Retrieving member records in a timely manner upon the request of an authorized party.
 3. Supervising the collection, processing, maintenance, storage, retrieval, and distribution of records.

Providers and hospitals are required to maintain legible, current, organized, and detailed medical records for every patient in accordance with national standards. The records must demonstrate all aspects of patient care, including any ancillary services. Documentation in the medical record shall be timely and permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare professionals' findings
- Appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided to the member.

The member record shall be signed by the provider of service. SECUR may conduct HIPAA privacy and security audits to assure compliance as required by SECUR.

Medicare laws require that medical records are retained for a minimum of ten (10) years from the end of contract with SECUR or the period under applicable laws, rules, and regulations, whichever is later.

6.2 Medical Records Requests

In accordance with the agreement and this manual, the medical records must be available for utilization review, risk management and peer review studies, customer service inquiries, grievance and appeals, and quality improvement initiatives.

Providers and hospitals must make medical records for all SECUR's members available for review and copying, including electronic copies for any regulatory agencies' requests free of charge.

Providers and hospitals must respond and submit requested medical records to SECUR's Grievance and Appeals Department promptly to enable SECUR to comply with federal and Florida laws governing grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with a copy of the record. The submission should include test results, office notes, referrals, telephone log, and consultation reports, as applicable.

Medical records may also be requested for quality improvement initiatives or risk adjustment chart reviews. Records must be provided to SECUR Quality Department when requested for these instances in the time limit indicated in the request.

If a member changes PCPs, medical records should be forwarded to the new PCP within fourteen (14) business days of receipt of a signed request.

6.3 Medical Record Alteration or Falsification

Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:

1. All incidents of possible medical record falsification are reported to SECUR's Peer Review Committee.
2. The Peer Review Committee reviews the records in question and allows the provider or hospital to explain the circumstances.
3. The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate action.
4. Health professionals, not subject to the peer review process (nurse, lab personnel, etc.), may be reported to the appropriate agency and/or governing body.

For additional information on the peer review process, see the section on Provider Disciplinary Actions in this manual.

6.4 Transfer of Medical Records upon Termination of the Agreement

Upon the effective date of termination of the agreement (and the expiration of any period of any continuing care obligation), or such earlier date as a member may select or be assigned to another provider or hospital, regardless of whether the agreement then remains in effect, pursuant to a member's or SECUR's request, provider shall copy all such member's medical records in provider's or hospital's possession and forward such records, at no cost to SECUR

or to the member, to (i) such other provider or hospital as designated by SECUR; (ii) the member; and (iii) SECUR as requested by SECUR or the member.

6.5 Member Consent

Where required by law, providers and hospitals shall obtain specific written authorization from a member prior to releasing such member's medical records. Providers and hospitals acknowledge and agree that the consent by a member in the applicable SECUR Medicare Plan enrollment form and/or providers' and/or hospital's standard consent form is hereby deemed satisfactory member consent for the release of members' records, to the extent required by applicable law.

6.6 Member's Rights to Access Medical Record

Providers and hospitals shall ensure timely access by members to review, amend, and obtain a copy of their medical records upon request, to the extent required by applicable law.

Provider Manual

Section 7.0

Providers' and Hospitals' Obligations

7.0 Providers' and Hospitals' Obligations

7.1 Consultations

Providers and hospitals shall participate in all programs instituted by SECUR to consult with its Providers and hospitals to assure compliance with federal, state, and accreditation organization standards.

7.2 Regulation and Accreditation

Providers and hospitals shall comply with the applicable provisions of this manual and cooperate with and participate in all internal and external Quality Improvement Organization (QIO) review processes; independent quality review and improvement organizations' activities; utilization management, including patient assessment and disease management programs, credentialing and re-credentialing, and quality assurance and management and other administrative activities, including site medical audit reviews and medical record charting and compliance audits, financial audits and post audit interviews by SECUR personnel or internal or external financial or other audit programs; performance improvement projects; HEDIS™ reporting requirements and performance measurement and reporting activities, in each case consistent with applicable law as may be established or implemented by SECUR or its designees from time to time, including but not limited to SECUR nurse reviewers. Providers and hospitals shall comply with all final determinations rendered by SECUR in connection with any of the foregoing. Providers and hospitals shall cooperate and participate in any program required for SECUR's compliance with the Medicare programs and any other federal or state laws and regulations or the rules and regulations of Accreditation Organizations. Providers and Hospitals shall grant SECUR, CMS, OIR, any accreditation organization, any QIO and any other agency with governing or accreditation authority over SECUR access to its facilities and records on reasonable notice during ordinary business hours for the purpose of conducting any reviews, audits, or site visits in connection with the foregoing in accordance with the agreement and this manual.

To the extent permitted by applicable law, providers and hospitals shall provide such medical and other records or data required by SECUR or any regulatory agencies governing SECUR in connection with the foregoing within ten (10) days of written notice to the provider or hospital without cost to SECUR or such sooner time as requested by SECUR in order for SECUR to comply with applicable law and regulations. For appeals and prior authorizations, these records should be submitted with the request.

7.3 Provision of Services

Provider shall provide services to members in accordance with the terms and conditions of the agreement, and shall be available, either through provider, a covering physician, or answering service twenty-four (24) hours a day, seven (7) days a week, to provide services to members in provider's office and arrange or provide services to members in any inpatient facility. The provider shall maintain an appropriately staffed office to provide services to members. Provider, a covering physician, admitting panel physician, or a hospitalist physician, as applicable, shall maintain appropriate staff privileges with at least one participating hospital.

Hospital shall provide services to members in accordance with the terms and conditions of the agreement and shall be available twenty-four (24) hours a day, seven (7) days a week, to provide hospital services to members. Hospitals shall maintain an appropriately staffed facility to provide hospital services to members.

7.4 Access to Care and Service Standards

Providers shall have an appointment system to schedule officer visits and offer appointments and access to members within the following guidelines:

Appointment availability shall be:

- For routine non-symptomatic care and physicals — as soon as available
- For routine symptomatic cases — within two (2) weeks
- For urgent care — within twenty-four (24) hours
- For emergent care — immediately
- For sick care — within a calendar week

Member telephone calls to Provider offices shall be returned as follows:

- Urgent – within thirty (30) minutes
- Emergent – immediately
- Routine – within one (1) business day

Members must be seen within one (1) hour of their scheduled appointment time. If the delay is unavoidable, the provider must inform the member and provide an alternative appointment time.

During site visits to the provider's office for credentialing, re-credentialing, medical record documentation reviews, and other provider representative office visits, SECUR will verify access standards by reviewing the providers' schedules of available appointments. Network management will review and intervene, when appropriate, based on member complaints about access to care and service and the provider's adherence to these standards.

7.5 Authorizing Treatment for Members

Providers and hospitals must contact SECUR via telephone, fax, or via online Provider Portal to obtain a prior authorization prior to scheduling a member for any medical service listed as

indicated in the member’s benefit plan, which may be amended by SECUR on an annual and as needed basis. Providers and hospitals shall use the Prior Authorization Request Form found in the Forms Section of this Manual or on the SECUR Provider Portal.

SECUR may require the submission of clinical information to support a Prior Authorization request. If the service is pre-authorized by SECUR, provider shall place the prior authorization number issued by SECUR on the form given to the member in order to ensure the provider or hospital to which the member is referred is properly paid. Hospitals shall notify SECUR of an admission occurring after providing Emergency Services.

Providers must contact SECUR to obtain prior authorization for the provider types or services listed in the following tables.

IMPORTANT – Prior authorization is not a guarantee of benefits or payment at the time of service. Benefits will vary between plans, so always verify benefits. This list is not intended to be all-inclusive. It includes tests that are most frequently requested and require prior authorization.



2026 Authorization Guidance

SECUR Health Plan reviews plan offerings including those services requiring prior authorization on an annual basis. This reference tool is a summary of the Evidence of Coverage (EOC) outlining services that require authorization. For additional information, please visit www.securhealthplan.com.

2026 General Coverage Guidance

Covered Services that Require Prior Authorization	Services that are NOT covered by Medicare
<p>Based on the Plan Evidence of Coverage (EOC), the following services require prior authorization. For additional information, please visit www.securhealthplan.com.</p> <ul style="list-style-type: none"> ▪ Cardiac Rehabilitation Services ▪ Chiropractic Services ▪ Dental Services (not covered by Plan Supplemental Benefits – see EOC) ▪ Durable Medical Equipment (DME) including skin substitutes and biologics ▪ Genetic Lab Testing ▪ Hearing Aids ▪ Home Health Services ▪ Home Infusion Therapy ▪ Hospital Observation Services ▪ Inpatient Services (Emergent and Elective) ▪ Long Term Acute Care Hospitals and Related Services ▪ Certain Medicare Part B Drugs ▪ Non-Emergent Ambulance Transportation (not covered by Plan Supplemental Benefits – see EOC) ▪ Opioid Treatment Programs and Services ▪ Outpatient Hospital Services ▪ Outpatient Psychotherapy Services ▪ Outpatient Substance Abuse Services ▪ Outpatient Surgeries and Procedures ▪ Partial Hospitalizations ▪ Prosthetics and Orthotic Devices ▪ Pulmonary Rehabilitation Services ▪ Radiology Services ▪ Inpatient Rehabilitation Services ▪ Supervised Exercise Therapy ▪ Skilled Nursing Facility Services ▪ Wound Care ▪ <i>All Out of Network Services</i> 	<p>Below are services excluded from Medicare coverage and are not covered by SECUR Health Plan. Plan specific supplemental benefits may allow for coverage of certain services on this list. Refer to the Plan Evidence of Coverage (EOC) for additional information located at www.securhealthplan.com.</p> <ul style="list-style-type: none"> ▪ Acupuncture** ▪ Cosmetic Surgery and Related Procedures ▪ Custodial Care ▪ Experimental Medical and Surgical Procedures, Equipment, and Medications** ▪ Fees charged for care by relatives or members of the household ▪ Full-Time, in home, nursing services ▪ Home Delivered Meals ▪ Homemaker services including basic household assistances, housekeeping, meal prep ▪ Naturopath Services ▪ Non-routine Dental Services** ▪ Orthopedic Shoes or Supportive Devices for the Feet** ▪ Personal Items at Hospital or SNF such as telephone or television ▪ Private Hospital Room ▪ Reversal of Sterilization Procedures and Non-Prescription Contraceptives ▪ Routine Chiropractic Services ▪ Routine Dental Services ▪ Routine Eye Exams, Eyeglasses, Radial Keratotomy, LASIK surgery, and other low vision aids ▪ Routine Foot Care ▪ Routine Hearing Exams, Hearing Aids, or Exams to Fit Hearing Aids ▪ Services considered not medically reasonable and necessary according to Traditional Medicare

*This is not a comprehensive or all-inclusive list. Services marked with “**” may be covered in limited circumstances. Additional information can be found in the Evidence of Coverage (EOC) available at www.securhealthplan.com.*

Supporting documentation will be required to determine the request. The above is just an abbreviated list. For the full list, please visit this link on the website:

<https://securhealthplan.com/wp-content/uploads/2025/12/2026-Coverage-Guidance.pdf>

To contact SECUR for an authorization:

Phone: 1.833.76SECUR (1.833.767.3287)

Fax Request Form to: 1.833.852.3607

<https://pm-secur.mirrahealthcare.com/>

Utilization Management Portal (Calypso Lyte): <https://um-SECUR.mirrahealthcare.com>

Emergency services do not require prior authorization.

The prior authorization request form and the following form are on SECUR's website securhealthplan.com:

- Disease and Case Management Referral Form

SECUR provides the opportunity for the provider to discuss a decision with the medical director prior to rendering the determination on a prior authorization request, to ask questions about any utilization management issue, or to seek information about the utilization management process and the authorization of care by calling the Health Services Department at 1.833.76SECUR (833.767.3287).

7.6 Timeliness of Authorizations

SECUR shall use its best efforts to provide requested prior authorizations as quickly as the member's health condition requires, but no later than CMS required timeframes. Standard prior authorization requests will be completed within seven (7) calendar days of SECUR's receipt of the request unless an extension is required. SECUR's review determination will be communicated verbally and/or in writing to the requesting provider and member at the time the decision is made. All denial determinations will be made by SECUR's medical director. Any denial determination will be sent to the provider or hospital by fax and/or mail and to the member by mail.

Urgent prior-authorization requests will be processed within seventy-two (72) hours of SECUR's receipt of the request unless an extension is required. The review determination and approval, partial approval, or denial will be communicated to the requesting provider or hospital and member at the time the decision is rendered followed by written notice within three (3) calendar days.

7.7 Reportable Diseases

Pursuant to Rule 64D-3.029, Florida Administrative Code, the Florida Department of Health requires that all health practitioners immediately report by phone (850.245.4401) suspected or confirmed cases of certain infectious diseases. These cases must be reported to the Florida Department of Health's appropriate county (381.0031(4), f.s). The County Health Contact list can be viewed at this link: [County \(floridahealth.gov\)](#). The listing of diseases can be accessed at this link: [Microsoft Word - Reportable Diseases List - Practitioners \(2021-12-27\) Modifiable \(floridahealth.gov\)](#).

7.8 Cultural Competency in Communications on Treatment Options

Provider and hospital shall provide information in a culturally competent manner to all members and consider and take measures to accommodate, at the provider's or hospital's sole cost and expense, member's limited English proficiency, reading skills, diverse cultural and ethnic backgrounds and physical or mental disabilities, including but not limited to hearing and vision impairments, when discussing a member's treatment options, including the option of no treatment.

7.9 Direct Access and Cost-Sharing

Providers and hospitals shall, as mandated by state or federal law, the applicable SECUR, Medicare Plan and this manual:

1. Allow members direct access to certain specialist physicians.
2. Not inhibit members' self-referral for certain services, including mammography screening and influenza vaccinations.
3. Not impose cost-sharing on any member for influenza or pneumococcal vaccines.
4. To the extent permitted by applicable law and this manual, members may self-refer without a PCP referral for:
 - (a) Mental and Behavioral Health Services
 - (b) Gynecologists/Obstetricians
 - (c) Chiropractors
 - (d) Podiatrists for routine care
 - (e) Optometrists if such services are covered for the member
 - (f) Dermatologists, for up to five (5) visits a year for routine care, in addition to any other services for which applicable law allows direct access.

7.10 Member Responsibility

Providers and hospitals acknowledge and agree that SECUR shall have no financial or other liability with respect to a member's failure to pay providers or hospitals amounts due the provider or hospital for copayment, coinsurance, or deductible as required under the member's SECUR Medicare Plan or for non-covered services. Providers and hospitals may not refuse to provide services to an eligible member solely because the member fails to pay the applicable co-payment at the time services are rendered.

7.11 Continuity of Care

Upon termination of this agreement, provider and hospital shall arrange and provide continuation of care for members utilizing provider or hospital or for whom treatment is otherwise active with provider and hospital until the earlier of: (a) the completion of treatment of a condition for which the member is receiving care on the effective date of termination of the agreement; (b) the date on which the transfer of such member's care to another provider or hospital can be arranged by SECUR; provided, however, that provider and hospital shall not be required to provide such continuation of coverage and care to any member longer than six (6) months after the effective date of termination of the agreement.

Notwithstanding the foregoing, SECUR shall allow provider and hospital to continue providing care after the termination of the agreement for any member who initiated a course of prenatal care, regardless of the trimester in which care was initiated, until completion of postpartum care, as applicable. Notwithstanding anything herein to the contrary, if termination of the agreement occurs during the insolvency of SECUR or in the event that the contract between CMS and SECUR terminates or is not renewed for any reason whatsoever, provider and hospital shall provide provider services or hospital services, as applicable, to members for the duration of the later of: (i) the period for which the member made payment under his/her SECUR Medicare Plan or for the duration of the contract period for which CMS payments were made to SECUR on behalf of the member, as applicable; (ii) the duration of any stay by the member in an inpatient facility on the date of insolvency or, in the event that the contract between CMS and SECUR expires or terminates, until the member is discharged from such facility; or (iii) such longer period of time as may be necessary for SECUR to remain in compliance with federal and state laws and regulations, including, without limitation, Medicare and Medicaid. During any such continuation of care period, SECUR shall compensate the provider and hospital in accordance with the agreement for care rendered to any member and provider and hospital shall be bound by the terms of the agreement and this manual.

7.12 Notice of Certain Actions or Events

Provider and hospital shall immediately notify SECUR, in writing, of any of the following actions taken by or against provider and hospital:

- (i) Surrendering, revocation, or suspension of any license, certification, registration, or permit pertaining to the services provided under the agreement.
- (ii) Any action to restrict, suspend, or revoke provider's or hospital's right to participate in the Medicare or Medicaid program or provider's clinical or staff privileges at any hospital or healthcare facility or if provider or hospital voluntarily relinquishes any of the foregoing.
- (iii) Any claim alleging provider's or hospital's medical malpractice, notice of intent to initiate litigation filed against provider or hospital or summons or complaint alleging provider's or hospital's medical malpractice.
- (iv) Any lapse or material change in provider's or hospital's professional liability insurance as required under the agreement and this manual.
- (v) Any indictment or conviction of provider or hospital for a felony.
- (vi) Any disciplinary action, fine, penalty, or other sanction imposed upon provider or hospital by any other local, state, or federal regulatory agency or notice of the commencement of a proceeding that could lead to any of the foregoing.
- (vii) Any other situation, including provider's or hospital's bankruptcy or insolvency or loss of any board certification, which might materially adversely affect provider's or hospital's ability to carry out provider's or hospital's duties and obligations under the agreement, or which would materially change the representations made in provider's or hospital's credentialing or recredentialing application. Such notice shall be sent to:

SECUR Health Plan
ATTN: Credentialing
12470 Telecom Drive, Suite 301
Temple Terrace, FL 33637
Fax: 833.852.8852
credentialing@securhealthplan.com

7.13 Non-Covered Services

In the event SECUR determines certain hospital services to be more appropriately provided in a setting other than hospital, as determined solely by SECUR, hospital shall not deem such hospital services to be non-covered services to allow hospital to directly bill a member for such services, unless otherwise determined to be non-covered services by SECUR at its sole discretion. The hospital acknowledges and agrees that certain services that are not payable by SECUR may in fact be covered services. For purposes of the agreement, a “non-covered service” is a service deemed not to be a covered service under the relevant SECUR Medicare Plan by SECUR at its sole discretion.

7.14 Care Management

As required by applicable law, SECUR has procedures to identify, assess, and establish care plans for persons with complex or serious medical conditions. With respect to individuals with complex or serious medical conditions, hospitals and providers shall assist SECUR in (i) identifying such individuals; (ii) diagnosing, assessing, and monitoring such individuals; and (iii) establishing and implementing treatment plans for such individuals that (a) are appropriate for their condition; (b) are time-specific; (c) are updated periodically; (d) ensure adequate coordination of care among providers; and (e) include an adequate number of direct access visits to providers consistent with the treatment plan.

7.15 Fraud Prevention

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These Acts outline the civil penalties and damages against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. In this regard, U.S. agency means any reimbursement made under Medicare or Medicaid, including SECUR. The Acts prohibit anyone from knowingly making or using a false record or statement to obtain approval of a claim.

Knowingly is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but also situations in which the person acts in deliberate ignorance of, or in reckless disregard of the truth or falsifies the claim.

SECUR has developed a Program Integrity plan of internal controls, policies, and procedures for preventing, identifying, and investigating member and provider fraud, waste, and abuse. Our plan includes:

- Enforcement of standards through disciplinary guidelines.
- Provisions for internal monitoring and auditing of both the member and the provider.
- Provisions for internal monitoring and auditing of subcontractors.
- Processes to collect outstanding debt from providers.
- Procedures for appeals.

- Programs that run algorithms and edits on claims data to identify outliers, patterns, and trends.

SECUR's Compliance Department conducts fraud, waste, and abuse investigations. The Programmed Investigation Unit (PIU) is comprised of staff from a broad range of SECUR departments.

Providers are required to cooperate with the investigation of suspected fraud, waste, and abuse. If you suspect fraud, waste, or abuse by either a SECUR member or a provider, it is your responsibility to report this information immediately.

Contact SECUR's Compliance Department if you have information relating to suspected fraud, waste, or abuse. There are several ways in which you may contact us:

- Writing: Compliance Department, SECUR Health Plan, 12470 Telecom Drive, Suite #301, Temple Terrace, FL 33637
- Email: compliance@securhealthplan.com
- SECUR Compliance Hotline: 1.833.76SECUR (1.833.767.3287)

The department will review the information and maintain the highest level of confidentiality.

You also have the option of contacting the Office of Inspector General for reporting fraud:

- Phone: 800.HHS.TIPS (800.447.8477)
- Website at: <https://oig.hhs.gov/fraud/report-fraud/index.asp>
- [Online OIG Hotline form](#)

To meet federal regulation standards specific to fraud, waste, and abuse, providers and their employees must complete an annual fraud, waste, and abuse training.

7.16 Suspected Adult Abuse or Neglect

Cases of suspected adult abuse or neglect might be uncovered during examinations. Abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission or neglect.

Suspected cases of abuse or neglect must be reported to the **Adult Protective Services Unit (APS)**. APS are services designed to protect elders and vulnerable adults from abuse, neglect, or exploitation. The Department of Elder Affairs (DOEA) and Department of Children and Families (DCF) have defined processes for ensuring that elderly victims of abuse, neglect, or exploitation in need of home and community-based services are referred to the aging network, tracked, and served in a timely manner. Administrative requirements for serving elderly victims of abuse, neglect, and exploitation can be found in Section 2.4.

In Florida, the DOEA works in conjunction with the DCF, APS, and the Aging Network to protect disabled adults or elderly persons from abuse, neglect, or exploitation.

To report suspected abuse, neglect, or exploitation of children or vulnerable adults, providers should call:

- **Florida Abuse Hotline** at **1.800.962.2873 (TTY 1.800.955.8771)** twenty-four (24) hours a day, seven (7) days a week. If a provider sees a vulnerable adult in immediate danger, he/she should call 911.
- **National Domestic Violence Hotline** is 800.799.7233, available 24/7/365, interpreter services are available.

7.17 Confidentiality

In accordance with federal and state laws, SECUR has established confidentiality policies and practices for its own operation and to outline expectations for our provider network. To obtain a copy of SECUR's Notice of Privacy Practices (NPP), please visit www.securhealthplan.com

All providers must comply with state and federal laws and regulations and SECUR's policies on the confidential treatment of member information in all settings.

All providers are to treat members' protected health information (PHI) — including medical records — confidentially and in compliance with all federal and state laws and regulations, including laws regarding mental health, substance abuse, HIV and AIDS, as well as the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to obtain the member's written consent for the purpose of sharing member health information.

Providers are authorized to share members' protected health information with SECUR for the purposes of treatment, payment, and healthcare operations, including requesting SECUR to process claims and administer reimbursement for the same.

Providers rendering services to SECUR's members are required to obtain special consent (authorization) from members for any uses or disclosures of protected health information beyond the uses of payment, treatment, and healthcare operations, unless otherwise permitted or required by law. Members have the right to specifically approve or deny the release of personal health information for uses other than payment, treatment, and healthcare operations. Examples of uses and disclosures that require special consent or authorization include data requested for workers' compensation claims, release of information that could result in the member being contacted by another organization for marketing purposes, and data used in research studies.

In cases where consent is required from members who are unable to give it or who lack the capacity to give it, SECUR and its providers will accept special consent or authorization from persons designated by the member. Designated persons, such as parents or guardians, may authorize the release of personal health information and may obtain access to information about the member. Information about a member transferred from SECUR to another organization as permitted by routine or special consent will be protected and secured according to SECUR's privacy policies and procedures and in compliance with state and federal privacy laws and regulations.

The provider agrees to cooperate with SECUR's Quality Management Program and all other quality management activities, including the use of performance data. The provider performance data may include, but is not limited to, medical records, provider experience, patient experience, and claims. The data received will be used in the development or in the improvement of activities and initiatives, credentialing activities, and public reporting to consumers. SECUR will use member information for quality studies, health outcomes measurements, and other aspects of healthcare operations and will de-identify the information as required by law.

SECUR's members are permitted to access, copy, and inspect their medical records upon request.

Provider Manual

Section 8.0

Hospital Emergency Services

8.0 Hospital Emergency Services

In the case of an Emergency Medical Condition, hospitals are not required to obtain prior authorization from SECUR prior to providing emergency services to members; provided, however, that upon admitting a member into the hospital, the hospital shall immediately notify SECUR of such admission and obtain the required prior authorization in accordance with this manual no later than the day of admission to the facility. Except for emergency services, coverage of all services rendered to members by the hospital is subject to SECUR's sole determination of whether such service is a covered service under the applicable SECUR Medicare Plan. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, the hospital must comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member. A hospital's failure to so obtain all required prior authorizations for non-emergency services may, at SECUR's sole discretion, result in SECUR's denial of payment for such services as set forth in the agreement. Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospitals acknowledge and agree that SECUR has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the manual.

8.1 Follow-Up Care

Hospital shall coordinate the provision of hospital services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, as otherwise permitted under the manual or applicable state or federal law or upon the prior written approval of SECUR's medical director or his/her designee(s), shall not provide any follow-up care or additional hospital services to members other than the covered services in accordance with the prior authorization for such services. Hospitals shall promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate prior authorization should a member require additional, or follow-up covered services.

Readmissions against benchmarks and tools for early recognition of condition change. SECUR or its contracted provider encourages facilities to utilize these tools to assist in reducing transfers and provides training on early identification of symptoms and provides their care coordinators with these tools. The program tools can be accessed at: <http://pathway-interact.com/>. Because the members have complex, multiple conditions, and significant functional limitations, the care managers take a very proactive role in healthcare delivery, monitoring, and communication. Each change of condition triggers a re-assessment of the follow-up visit schedule and designation of the provider type and expertise required to best manage the current conditions and foster stabilization or at a minimum determine advanced care plan that acknowledges the end-of- life issues.

8.2 Covering Physicians

Provider shall make necessary and appropriate arrangements with covering physicians to ensure the availability of provider services to members twenty-four (24) hours per day, seven

(7) days per week, including arrangements to ensure coverage of members after hours or when the Provider is otherwise unavailable. The provider shall ensure that covering physicians are providers, except as otherwise consented to by SECUR in writing or in the case of a locum tenens provider. Provider shall ensure that covering physicians adhere to the terms of the agreement and this manual and that covering physicians seek required prior authorization from SECUR or refer the member back to the member's PCP, as required by this manual, except for emergency services or urgently needed services or as otherwise permitted under the applicable SECUR Medicare Plan. Except for hospitalist physicians, with respect to capitated services (as defined in the agreement), provider shall be solely liable to covering physicians for the amount and manner in which covering physicians are reimbursed or otherwise compensated for services rendered to members on provider's behalf. Providers acknowledge and agree that SECUR shall not have any financial obligation whatsoever to covering physicians with respect to capitated services. Providers shall ensure that covering physicians do not, under any circumstances, bill members for covered services other than for applicable copayments, deductibles, and coinsurance. Providers hereby agree to indemnify and hold harmless members, AHCA, OIR, and CMS against charges for covered services rendered by covering physicians. All charges incurred for services rendered pursuant to a prior authorization or referral made by a covering physician, other than a referral back to the member's PCP, shall, unless such prior authorization or referral was approved by SECUR in advance and in writing or as otherwise permitted under the applicable SECUR Medicare Plan, be borne by providers who shall be liable for all costs, fees, charges, and expenses associated with such services.

Provider Manual

Section 9.0

Pharmacy

9.0 Pharmacy

SECUR's Pharmacy Department is open from 8 a.m. to 5 p.m., Monday through Friday. SECUR utilizes a Pharmacy Benefit Manager (PBM), to administer its prescription drug program. The Pharmacy Benefits Management organization is **Navitus Health Solutions**. You may reach them 24 hours a day at 1.866.270.3877.

9.1 Drug Formulary

A Formulary is a list of covered drugs selected by SECUR in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. SECUR will generally cover the drugs listed in our Formulary as long as the drug is being used for a medically accepted indication as defined by Medicare, the prescription is filled at a SECUR network pharmacy, and other plan rules are followed.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Requires approval from SECUR before the member can fill the prescription. If approval is not given, SECUR may not cover the drug.
- **Quantity Limits:** For certain drugs, SECUR limits the amount of the drug that it will cover. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, SECUR requires a trial of certain drugs for treating a medical condition before another drug for that condition will be covered. For example, if Drug A and Drug B treat the same medical condition, SECUR may not cover Drug B unless Drug A is tried first. If Drug A does not work or is likely to cause an adverse effect, SECUR will then cover Drug B.

If a drug is not included in this Formulary, you can prescribe a similar drug that is on the Formulary and covered or ask SECUR to make a coverage decision for the requested drug.

You can find out which drugs have requirements or limits by looking in the Formulary or by calling us. To obtain a copy of the Formulary, visit SECUR Health Plan's [Drug Coverage page](#) on the website.

9.2 Coverage Determinations

9.2.1 Part D Coverage Decisions

A coverage decision is a decision SECUR makes about benefits and coverage or about the amount we will pay for prescription drugs. An initial coverage decision about Part D drugs is called a "coverage determination." The member, member's appointed representative, or prescriber can ask for a coverage determination. Here are examples of coverage decisions:

- Asking us to cover a drug on our Formulary and you believe any applicable coverage rules (e.g., prior authorization) for the drug have been met.
- Asking us to make an exception, including:
 - Asking us to cover a drug even if it is not on our Formulary. If approved, this drug will be covered at a pre-determined cost-sharing level and cannot be provided at a lower cost-sharing level.
- Asking us to waive a restriction on the plan's coverage for a drug. For example, if a drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- Members can ask us to pay for a prescription drug that was already bought. This is a request for a coverage decision about payment.

Generally, SECUR will only approve your request for an exception if the alternative drugs included on the plan's Formulary, or additional utilization restrictions would not be as effective in treating the member's condition and/or would cause the member to have adverse effects. **When an exception is requested, a prescriber's statement indicating such factors is required to support the exception's request.**

If SECUR denies a coverage decision, the member, member's appointed representative, or prescriber can appeal our decision. See "Prescription Drug (Part D) Appeals for Medicare members" below for additional information.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A **standard coverage decision** means we will give you an answer as quickly as the member's health condition requires, but **no later than seventy-two (72) hours** after we receive the request or prescriber's supporting statement for exceptions. If your member's health requires a quick response, you must ask us to make an "expedited coverage decision." An **expedited coverage decision** means we will answer as quickly as the member's health condition requires, but **no later than twenty-four (24) hours** after we receive the request or prescriber's supporting statement for exceptions.

Requests for coverage determinations can be made orally or in writing. While written requests will be accepted in any format, a coverage determination request form is available for use in the "Forms" section of this manual. To request a coverage determination:

- Fax: 855.668.8552
- Visit the website at: [Navitus Provider Portal](#)
- Call: 844.268.9789

- Write:
SECUR Health Plan
P.O. Box 1039
Appleton, WI 54912-1039

9.2.2 Part B Coverage Decisions

A coverage decision is a decision we make about benefits and coverage or about the amount we will pay for Part B prescription drugs covered under a member's medical benefit.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A **standard coverage decision** means we will give you an answer as quickly as the member's health condition requires, but **no later than seventy-two (72) hours** after we receive the request or prescriber's supporting statement for exceptions. If your member's health requires a quick response, you must ask us to make an "expedited coverage decision." An **expedited coverage decision** means we will answer as quickly as the member's health condition requires, but **no later than twenty-four (24) hours** after we receive the request or prescriber's supporting statement for exceptions.

Requests for coverage determinations can be made orally or in writing. While written requests will be accepted in any format, a coverage determination request form is available for use in the "Forms" section of this Manual. To request a coverage determination:

- Fax: 833.852.3607
- Visit the website at: securhealthplan.com
- Call: 833.76SECUR (833.767.3287)
- Write:
SECUR Health Plan
12470 Telecom Drive, Suite 301, Temple Terrace, FL 33637

Provider Manual

Section 10.0

Quality Management

10.0 Quality Management

SECUR's Quality Management Department identifies high-volume, high-risk, and problem prone areas of care and service affecting members and establishes Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIP). To the extent required by applicable law and regulations and requirements of Accreditation Organizations, SECUR's Quality Management department also:

- Disseminates nationally developed guidelines for preventive care, screening, and treatment.
- Undertakes quality improvement initiatives.
- Audits medical records and provides feedback on the results of those audits to Providers.
- Conducts retrospective review and investigation of complaints about quality of care.
- Shares findings with other peer review committees, such as the Credentialing Committee.

Annually, HEDIS data is collected through a contracted vendor or by clinical staff under the direction of SECUR's Quality Management department. SECUR collects as much of the data as possible from Claims and Encounter Data. However, chart reviews are required when Claims or Encounter Data need verification or the data is not available. Providers shall allow the SECUR vendor or staff to access member medical records for HEDIS, or any other data collection purposes.

10.1 Risk Management Program

- Providers shall participate in and cooperate with SECUR's Risk Management Program. SECUR developed and implemented an incident reporting system to minimize injury/incidents to members, employees, and visitors.
- Complete the Incident Report form immediately when becoming aware of an Adverse or Untoward incident.
- Fill each blank on the form, using N/A when something is not applicable to the occurrence.
- Write legibly or type the information on the form.
- Describe the incident carefully. Be brief, but include important information, including who, what, where, when, and how.
- Indicate the body part injured, location, and extent of injury and document fully, including lack of injury.
- Report any pertinent action taken in response to the occurrence.
- Obtain the name and location information for any witnesses, including employees.
- Sign and date the report. Include title/designation and contact phone number.
- Fax to 813.357.5352, ATTN: Risk Manager.

For assistance in completing the Incident Report form, contact SECUR's Risk Manager at 1.833.76SECUR (833.767.3287).

Incident reports are part of SECUR's Risk Management files only and copies of incident reports must be maintained separately from the member's medical records.

All incident reports will be reviewed, and date stamped upon receipt. Appropriate action will be initiated when indicated. Incident reports will not be used to penalize providers or hospitals. However, failure to report an Adverse or Untoward Incident may be cause for disciplinary action by SECUR.

Provider Manual

Section 11.0

Disciplinary Action

11.0 Disciplinary Action

In addition to other rights and remedies available under the agreement, SECUR may take disciplinary action against a provider or hospital because of any adverse quality of care, utilization, licensure, credentialing, and/or administrative issues. Potential issues may be identified through a number of sources including, but not limited to, medical record reviews, complaint investigation, adverse and untoward incident monitoring, credentialing issues, quality improvement studies, and review and discussion of over and under-utilization that continues after an opportunity to correct such practices is not addressed by the provider or hospital.

The following SECUR governing bodies have the authority to recommend and implement disciplinary action against a provider or hospital:

- Quality Improvement Committee
- Peer Review Committee
- Risk Management Committee
- Credentialing Committee
- Compliance Committee
- The Chief Operating Officer may institute immediate disciplinary action in response to a state or federal license suspension, an imminent threat of patient harm, license revocation, or licensure sanctions.

11.1 Peer Review Determination and Actions

As required by applicable law and regulations and Accreditation Organization requirements, all Potential Quality of Care Issues (PQIs) relating to the care and services rendered by SECUR Providers or Hospitals are investigated through the quality review process.

SECUR's quality manager and medical director evaluate the case and determine whether the issue is a Validated Quality of Care Issue (VQI) or not. SECUR's Peer Review Committee recommends an appropriate course of action to address Validated Quality of Care Issues.

11.2 Types of Sanctions

SECUR's Peer Review Committee may impose the following types of sanctions on any reviewed provider or hospital:

Typ	Explanation
Monitor	The Quality Management Department and the Peer Review Committee will continue to review this provider's or hospital's performance.
Educate	The Peer Review Committee may require the provider or hospital to take additional CME programs on a specific clinical topic and provide proof of completion.
Counsel	SECUR's medical director shall meet with and counsel the provider or hospital.
Probation	SECUR will provide focused oversight on the actions taken by this provider or hospital for a specified period. The provider's panel may be frozen during this period of time.
Suspension	The provider or hospital may be suspended from the SECUR's network for a period of time.
Termination	The agreement with the provider or hospital may be terminated.

If the Peer Review Committee finds a Validated Quality of Care Issue, the committee notifies the provider or hospital of the determination within five (5) working days of the meeting. The letter to the provider or hospital will contain:

- Determination of the Peer Review Committee
- General description of the basis for the determination
- Specific actions the provider or hospital must take to correct the issue/problem and prevent recurrence
- Description of the process that will be used to evaluate the effectiveness of the intervention
- The provider's or hospital's appeal and hearing rights.

The provider or hospital may disagree with the determination of SECUR's Peer Review Committee and decide to file an appeal. A provider or hospital request for an appeal hearing must be in writing and must be received within ten (10) business days of receipt of the Peer Review Committee determination letter.

The appeal will be heard at the next scheduled meeting of SECUR's Peer Review Committee. The provider or hospital may provide additional information to the Peer Review Committee to support their appeal. The provider or hospital may participate in the appeal hearing in person or by telephone.

SECUR's Peer Review Committee will review all information submitted and presented at the appeal hearing. The committee will either overturn or uphold their earlier determination, sanction points, and corrective action plan. The decision of SECUR's Peer Review Committee will be

communicated to the provider or hospital in writing within five (5) business days of the appeal hearing.

Pursuant to the imposition of a corrective action plan, the Peer Review Committee evaluates the effectiveness of the intervention. The committee makes one of the following determinations:

- The intervention was acceptable. A letter is prepared and sent to the provider or hospital stating that the quality concerns were addressed.
- The intervention was not accepted. The committee may recommend additional actions. A notification letter to the provider or hospital will be sent to the provider or hospital. The committee may suspend the provider or hospital, terminate the provider or hospital, freeze, or move the provider's or hospital's membership. Issues that may be brought to the committee that are not related to clinical competency include but are not limited to the following:
 - Failure to respond to notice of deficiencies in medical records.
 - Failure to participate in Quality Management or Peer Review activities.
 - Failure to meet other contractual requirements not related to clinical competency.
 - Evidence of illegal use of narcotics or other intoxicants.
 - Unethical conduct.
 - Failure to cooperate with SECUR's quality improvement program.
 - Failure to cooperate with SECUR's utilization management program.
 - Failure to respond to an investigational request.
 - Failure to respond to or comply with a corrective action plan.
 - Failure to comply with quality management or risk management guidelines
 - Insubordinate activity by provider or hospital, including lack of cooperation with SECUR failure to comply with the terms of this manual or for other business reasons.

Any failures may result in corrective action by SECUR's Peer Review Committee, including termination. Based on grounds not related to clinical competency, termination shall not constitute grounds for a Peer Review Committee hearing.

Information gathered in the quality management and peer review process shall be shared with the Credentialing Committee.

11.3 Reporting to Regulatory Agencies

SECUR will report any decision to reduce, suspend, or terminate a provider's or hospital's participation in the SECUR network as required by applicable law and regulations.

11.4 Hearing Rights

SECUR shall provide hearing rights to all physicians with SECUR. Medicare members, terminated with or without cause; provided, however, that if the member's health is in imminent danger, SECUR may terminate the practitioner in accordance with the agreement and subsequently offer the practitioner its hearing rights.

All hearings will be held before a hearing panel consisting of members: (i) the majority of who are peers of the affected practitioner and (ii) who are not in direct economic competition with the affected practitioner. A provider or hospital afforded hearing rights may file an appeal within seven calendar days of receipt of the termination notice. Any appeal filed after this deadline will be rejected for late filing. The SECUR Appeals Committee shall hear the reasons for the termination request and the grounds of the provider's or hospital's appeal. Decisions of the

Appeals Committee will be made within two (2) workdays. The decision of the hearing panel is final and shall be communicated to the provider or hospital via certified mail.

Provider Manual

Section 12.0

Grievance and Appeals

12.0 Grievance and Appeals

SECUR as an MA-PD plan with CMS has policies and procedures to address a medical or pharmacy complaint, grievance, or appeal received on behalf of SECUR members.

12.1 Medicare Part C – Medical Services and Items

12.1.1 Member Grievances and Appeals (Reconsiderations)

SECUR has established and shall maintain a grievance and appeal procedure for the resolution of grievances, appeals, and expedited grievances and appeals involving members, a copy of which is available to providers, hospitals, and pharmacies on request.

Providers and hospitals agree that any dispute, complaint, grievance, appeal, or claim asserted pursuant to the agreement, any Medicare Plan or otherwise or in connection with the provision of covered services under the agreement shall be resolved in accordance with SECUR's grievance and appeal procedure, including procedures for expedited review of determinations and reconsiderations upon the request of a Medicare member and in accordance with Medicare law.

Providers and hospitals shall cooperate with SECUR in connection with its resolution of any grievance or appeal, including gathering and forwarding any and all information, including but not limited to medical records, requested by SECUR or any governmental agency in connection with the investigation and resolution of such grievance or appeal, at no cost to SECUR within such timeframe requested by SECUR or as otherwise required by applicable law or this Manual.

SECUR shall have final authority over the resolution of all grievances and appeals, and providers and hospitals shall comply with all final determinations made by SECUR pursuant to its grievance and appeal procedure. In the event an oral or written grievance or appeal is presented to a provider or hospital by a member, such provider or hospital shall immediately notify SECUR of such grievance or appeal and provide SECUR with a copy of the grievance or appeal if in writing.

12.1.2 Grievance Process for Medicare Members

The grievance procedure applies to Medicare members who are dissatisfied with the healthcare services they received or any other aspect of SECUR.

A written or oral grievance may be filed by a current or former Medicare member or his/her authorized representative. If a Medicare member wishes to act through an authorized representative, an Appointment of Representative form must be signed by the Medicare member, appointing another party to act on behalf of the Medicare member. SECUR's Grievance and Appeals Department will investigate the grievance and notify the Medicare member or the Medicare member's authorized representative in writing of a decision within thirty (30) calendar days of receipt of the grievance. For

grievances concerning quality of care issues, the investigation will include clinical peer review and/or medical director review, with formal reporting when appropriate.

12.1.3 Standard Reconsideration (Appeal) for Medicare Members

A reconsideration (appeal) consists of a review of an adverse organization determination or denial, in whole or part of a requested service. A Medicare member, his/her legal or appointed representative, or provider or hospital may request a reconsideration of an initial determination in writing via mail or via fax. The request must be filed within sixty-five (65) calendar days of the date of notice of the adverse initial determination. Extensions, however, may be granted upon request if SECUR determines that good cause exists. The request for reconsideration may be filed with SECUR, the Social Security Administration, or, when applicable, the Railroad Retirement Board. The Social Security Administration or Railroad Retirement Board will forward these requests to SECUR.

Providers and hospitals must redirect the Medicare member back to SECUR for all requests for reconsideration.

SECUR's Grievance and Appeals department is responsible for receiving and processing all requests for reconsideration and ensuring that all supporting documentation is obtained. If a member submits a verbal appeal request, SECUR will send a letter of acknowledgement to the Medicare member, authorized representative, or provider or hospital within five (five) business days of receipt of the request for reconsideration. A reconsideration decision will be made by someone other than the person involved in making the initial determination.

12.1.4 Expedited Reconsiderations (Expedited Appeals) for Medicare Members

Medicare members or their providers or hospitals may submit an oral or written request to SECUR for an expedited reconsideration of the initial pre-service determination. Any physician's request for an expedited review will be processed under the expedited time limit. If SECUR determines that the member's request for an expedited review is handled under the standard time frame for its reconsideration could seriously jeopardize the life or health of the Medicare member or the Medicare member's unborn child or seriously impair the Medicare member's ability to regain maximum function, SECUR will grant the request. Further, if a physician informs SECUR that the standard time limit for its reconsideration could seriously jeopardize the life or health of the Medicare member or the Medicare member's unborn child or seriously impair the Medicare member's ability to regain maximum function, SECUR will expedite the reconsideration.

12.1.5 Further Rights to Review for Medicare Members

If SECUR's reconsideration decision upholds the initial determination in whole or part, SECUR will forward the Medicare member's case to a CMS contractor for an independent review in accordance with federal law. The CMS contractor will inform the Medicare member and/or provider or hospital as well as SECUR of its decision. SECUR will notify the provider or hospital and Medicare member of decisions and actions.

If the CMS contractor upholds SECUR's decision, the Medicare member and, when appropriate, the provider or hospital will be informed of further rights to administrative and

judicial review. Providers and hospitals shall comply with and provide any care required by the ultimate decision rendered through the grievance and appeals process.

12.2 Medicare Part D – Prescription Drugs

12.2.1 Prescription Drug (Part D) Complaints for Medicare Members

A complaint regarding prescription drug benefits will be handled as a grievance, coverage determination, or an appeal, depending on the complaint. If the complaint is about decisions related to benefits, coverage, or payment, then the process for coverage decisions and appeals should be utilized. Complaints about the quality of care, waiting, times, customer service, and other concerns are considered grievances.

A grievance involves an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. For example, a Medicare member may file a grievance if they have a problem with things such as waiting times when filling a prescription, the way a network pharmacist behaves, not being able to reach someone by phone, or having difficulty getting information.

Part D grievances are answered as quickly as the member's health condition requires, but no later than thirty (30) calendar days after receiving the complaint. If the complaint was made because we denied the request for a "fast coverage decision" or a "fast appeal," we will automatically give an "expedited grievance" and provide an answer within twenty-four (24) hours of receipt of the grievance.

12.2.2 Prescription Drug (Part D) Appeals for Medicare Members

An appeal can be requested if the member, member's appointed representative, or prescriber disagrees with our decision to deny a request for coverage of prescription drugs or payment for drugs already received. When a decision is appealed for the first time, it is called a "redetermination" or "Level 1 Appeal."

In this type of appeal, we review the adverse coverage decision, including the findings upon which the decision was based, and any other evidence submitted or obtained. The appeal is handled by different reviewers than those who made the original decision. All appeal reviews involving medical necessity are performed by a physician with expertise in medicine appropriate for the drug in question.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard appeal means we will give you an answer as quickly as the member's health condition requires, but no later than seven (7) calendar days after we receive the request. If your member's health requires a quick response, you must ask us to make an "expedited appeal." An expedited appeal means we will answer as quickly as the member's health condition requires, but no later than seventy-two (72) hours after we receive the request. SECUR cannot extend the time limit for handling a standard or expedited Part D redetermination request.

Requests for redetermination can be made orally or in writing. While written requests will be accepted in any format, a redetermination request form is available for use in the "Forms" section of this manual. Redeterminations must be requested within sixty-five (65) calendar days from the date on the written coverage determination denial notice. If

the deadline is missed and there is a good reason for missing it, we may give you more time to submit an appeal. To request a redetermination:

Fax: 1.833.852.2651

Visit our website at: securhealthplan.com

Call: 1.833.76SECUR (1.833.767.3287)

Write: 12470 Telecom Drive, Suite 301, Temple Terrace, FL 33637

12.2.3 Further Prescription Drug (Part D) Appeal Rights for Medicare Members

If SECUR's redetermination decision upholds the initial determination in whole or part, the member, member's representative, or the prescriber (acting on behalf of the member) may request an independent review (i.e., "Level 2 appeal") by a CMS contractor in accordance with federal law. The CMS contractor will inform the Medicare member and/or prescriber, as well as SECUR of its decision.

If the CMS contractor upholds SECUR's decision, the Medicare member or prescriber (only if appointed as the member's representative) can request up to three additional levels of appeal after Level 2 so long as the value of the drug appeals meets a certain dollar amount for the specific appeal level.

Provider Manual

Section 13.0

Utilization Management Program

13.0 Utilization Management Program

13.1 Utilization Management Approach

Utilization Management (UM) is the evaluation of the medical necessity, quality, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health plan benefits. “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- “Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient Facility of a different type.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.
- Service-specific coverage requirements and medical necessity criteria can be found on the provider portal.
- Participating providers are required to obtain prior authorization for any medically necessary service to members, or when the service is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.
- UM decision making is based on appropriateness of care and service, existence of coverage, medical necessity, and available criteria. SECUR does not reward providers or other individuals conducting utilization review for issuing denials of coverage or services, and SECUR does not encourage decisions that result in underutilization.

13.2 Utilization Management Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the provider contract or in this manual. If prior authorization criteria are not met resulting in a denied claim, members must be held harmless for denied services.

The SECUR medical director renders all medical necessity denial decisions. Whenever a denial is issued, UM provides the name, telephone number, and title of the medical director who rendered the decision.

13.3 Second Opinions

SECUR gives members the right to a second medical opinion in any instance in which the member disputes SECUR's, the provider's, or hospital's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious illness or injury. If requested, the member may select a provider or a non-participating provider in the geographical service area of SECUR.

If the member selects a provider, the PCP may issue a referral for the second opinion. If the member selects a non-participating provider, the PCP must request a prior authorization from SECUR.

13.4 Case Management

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

The case management nurse will work with the provider, the member, and the member's family to help decrease the risk of complications, support coordination of care, and provide education. These nurses will work with providers to assess, plan, and monitor options and services for members with chronic illness or injury.

Case management services are also offered to members upon discharge from the hospital to help facilitate the receipt of post-discharge services administered by their provider.

13.4.1 Target Populations

Members who may benefit from case management are those with ongoing complex medical needs or those at risk for an avoidable adverse outcome/event. The following individuals may warrant case management; however, this listing is not meant to be all-inclusive:

- Individuals at risk for an avoidable outcome/event.
- Individuals with chronic physical health illnesses.
- Individuals with chronic behavioral health illnesses.

13.4.2 How are Referrals Generated?

Referrals to case management are received through many sources:

- Stratification
- Member Services line
- Completed Health Risk Assessments (HRAs)
- Recently discharged members from hospitals, or members who have required emergency room care
- Internal department referrals
- Providers seeking care management for their patients.

13.4.3 How to Request Case Management Services

Members may self-refer, and providers and hospitals may refer members to SECUR's Case Management Programs. Providers may request help to develop treatment plans for members with complex or serious medical conditions. To make such a referral or to request assistance, please contact Case Management at 1.833.767.3287. To refer a member to one of these programs, use the Disease and Case Management Referral Form in the Forms Section of this manual. Fax the form to 1.833.852.3607.

13.5 Institutional Special Needs Plan (I-SNP)

The I-SNP plan is intended to provide specialized services and meet the care coordination needs of beneficiaries who live in SECUR's proposed service area, and who for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), or an assisted living (AL), and/or are community-based with institutional level of care needs. SECUR enrolls individuals meeting:

- The institutional level of care as defined by CMS and who live in our targeted Florida counties (Citrus, Hernando, Hillsborough, Pasco, or Pinellas), and/or
- Are living in designated assisted living and nursing facilities served by SECUR's case management and care delivery partners.

Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that lead to improved healthcare outcomes, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the beneficiary's caregiver(s).

13.5.1 I-SNP Model of Care (MOC)

The Model of Care (MOC) provides the basic framework under which SECUR will meet each member's needs. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified by SECUR and addressed through the plan's case management practices. The MOC provides the foundation for promoting I-SNP quality, care management, and care coordination processes.

PCP and member specialist providers (including behavioral health providers) are an important part of the MOC process as they are needed for participation on the Interdisciplinary Care Team (ICT).

The composition of the ICT typically includes the member, the member's SECUR case manager or care coordinator, the member's caregiver (if any), the member's PCP or other specialist provider(s) and any community resources that might support the member's individualized care plan.

The role of the ICT is to review Health Risk Assessment responses that form the basis for the individualized care plan (ICP). The ICP is developed and reviewed with the member to promote member-driven engagement and empowerment for behavioral changes. The ICT uses healthcare outcomes to evaluate established processes to manage changes and/or adjustments to the member's healthcare needs continuously.

As a contracted provider in SECUR's network, you will receive invitations to attend ICT meetings to engage in supporting the needs of this specialized population. Your participation is highly encouraged.

13.6 Disease Management Programs

SECUR offers the following Disease Management Programs:

- Cardiovascular Disease
- Chronic Lung Disorder
- Diabetes

Each program is designed to support the provider in caring for members with these targeted conditions. The programs are designed to meet the special needs of members and can be partially modified or customized as needed based on the characteristics of the members enrolled in the program (e.g., mobility, cognitive acuity, age, ethnicity, language, etc.). The program offers education and health coaching focused on helping members learn skills to better manage their health. By utilizing the teach-back methods, the case manager, care Coordinator, or delegated entity confirms understanding of self-management plan. Members may be referred to or invited to participate in these programs through any of the following processes:

- Member completes a Health Risk Appraisal (HRA) form after enrollment and reports having the targeted condition.
- Member admitted to acute care facility and identified by a SECUR nurse as a potential candidate for the program. The nurse makes a referral to the care management program as appropriate.
- Member self-refers through SECUR's Member Services or the Member Portal.

When a referral is received, the integrated case manager contacts the member to explain the program. The SECUR staff uses translation services to support Spanish-speaking members. The case manager completes a comprehensive clinical assessment and sends an information packet to the member.

A follow-up call is scheduled with the member to finalize whether the member wishes to participate in the program. If the member decides to participate, a letter is sent to the member's PCP requesting additional clinical information. Frequent communication between the disease case manager and the member is scheduled to support education on the disease process, compliance, and to address any issues that might arise.

The member may telephone the case manager at any time during normal work hours, Monday through Friday, between 8 a.m. and 5 p.m.

13.7 Chronic Care Improvement Program (CCIP)

To support the PCP in managing the care of SECUR members, the plan offers a CCIP for the following condition:

- Diabetes

Potential members will be identified by SECUR. To be eligible, the member must have been with SECUR for at least six (6) continuous months.

Once the members are identified, SECUR will contact the member's PCP to participate in the program. A case manager will do a home visit for the member and develop a care plan with the PCP. The member, and member's family or caregivers will be involved in the program and care plan.

Provider Manual

Section 14.0

Member Preventive Care

14.0 Preventive Care and Immunization Schedules

14.1 Adult Member Preventive Care and Immunization Schedules

In its efforts to improve member awareness of nationally established screening guidelines for common disease states, SECUR supports the preventive care screening guidelines for adults recommended by the United States Preventive Services Task Force (USPSTF). Providers may access the USPSTF periodicity screening in its entirety at <http://www.ahrq.gov/clinic/pocketgd.htm>. Providers are encouraged to familiarize themselves with these guidelines and to incorporate them into their daily practice. As with all guidelines, they are intended to help prevent disease and identify and treat asymptomatic patients with pre-clinical disease. This guideline is referenced with the understanding that a physician's screening and treatment plan for any patient will be individualized. SECUR will review the above referenced guidelines annually. It is important to note that alternative screening guidelines exist, and physicians and members are encouraged to refer to other authoritative sources as their individual clinical situation may require.

Adult Preventive Medicine					
		Ages 18 – 35	Ages 40 – 49	Ages 50 -64	Ages 65+
Cancer					
Pelvic & Pap Test http://www.ahrq.gov/clinic/pocketgd.htm	Women	Begin within three (three) years of onset of sexual activity or no later than age 21. Pap test yearly (or every three (3) years after having three (3) yearly normal Pap tests). Stops at age 65 unless high risk (previous positive Pap tests or previous cervical CA).			
Mammogram http://www.ahrq.gov/clinic/pocketgd.htm	Women		Every 1-2 years	Yearly	Yearly until age 70.
Colonoscopy http://www.ahrq.gov/clinic/pocketgd.htm	Women/Me n			Fecal occult blood annually for age>50. Begin screening with sigmoidoscopy or colonoscopy at age 50.	
Cardiovascular Disease					
High Blood Pressure http://www.ahrq.gov/clinic/pocketgd.htm	Women/Me n	Note: New high blood pressure values – Normal <120/80; prehypertension 120-139/80-89; hypertension > 140/90			

Adult Preventive Medicine					
		Ages 18 – 35	Ages 40 – 49	Ages 50 -64	Ages 65+
Lipids http://www.ahrq.gov/clinic/pocketgd.htm	Women/Me n	Non-fasting total cholesterol and HDL-c beginning at age 35 for men and age 45 for women. Repeat every five (5) years. Have a fasting lipid profile done if total cholesterol > 200 or if other risk factors			
Infectious Diseases					
Chlamydia Screening http://www.ahrq.gov/clinic/pocketgd.htm	Women	All sexually active females younger than twenty (25) years of age and all pregnant females under twenty-five (25) years of age			
Hepatitis B http://www.ahrq.gov/clinic/pocketgd.htm	Women (Pregnant)	All pregnant women at first prenatal visit.			
Routine Preventive Care					
Immunizations http://www.cdc.gov/nip/recs/adult-schedule.htm	Women/Me n	Tetanus- Diphtheria (Td) – every ten (10) years Gardasil (HPV vaccine) – three dose series for females aged 9 - 26.	Tetanus- Diphtheria (Td) – every 10 years	Influenza yearly Zostavax (shingles) –one dose after turning age 60 Tetanus- Diphtheria (Td) – every 10 years	Pneumococcal – one dose routinely Tetanus- Diphtheria (Td) – every ten (10) years
Bone Mineral Content http://www.ahrq.gov/clinic/pocketgd.htm	Women			Screen all women > 65 years of age, at-risk women > 60 years of age. DXA of femoral neck is considered the best method	

Provider Manual

Section 15.0

Clinical Practice Guidelines

15.1 Quality Improvement Program (QI) Scope and Goals

SECUR's Quality Improvement (QI) Program addresses the quality of both clinical care and services provided to members and providers. QI activities encompass all demographic groups, benefits, and care settings.

It also addresses all healthcare services, including medical and behavioral, preventive, emergency, primary and specialty care, as well as acute care, short-term care, long-term care, home care, pharmacy, and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management
- Adoption and compliance with preventive health and clinical practice guidelines
- Behavioral healthcare management and coordination with medical practitioners
- Continuity and coordination of care
- Department performance and service
- Network provider profiling
- Employee and provider cultural competency, including monitoring to ensure member linguistic and physical accessibility
- Disparities in care
- Member grievance/Member satisfaction
- Health education and promotion
- Network accessibility and appointment availability, including specialty practitioners
- Patient safety, including appropriateness and quality of healthcare services
- Provider satisfaction
- Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and re-credentialing)
- Utilization management, including under and over utilization
- Compliance with preventive health and practice guidelines.

Provider Manual

Section 16.0 Performance Improvement Process

16.0 Performance Improvement Process

16.1 Healthcare Effectiveness Data Information Set

The Healthcare Effectiveness Data Information Set (HEDIS) is a group of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. Comparisons are based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA health plan accreditation, as well as HEDIS measures are becoming increasingly important, as purchasers of healthcare use the aggregated HEDIS rates to evaluate a health insurer's ability to demonstrate improvement in preventive health and outreach to its members.

16.2 Calculation of HEDIS Rates

HEDIS rates may be calculated using two (2) methodologies: administrative data methodology or hybrid methodology. Administrative data methodology is calculated from claims or encounter data submitted to the health plan by providers. Measures typically calculated using administrative data methodology include annual mammogram, antidepressant medication management, access to PCP services, and utilization of acute and mental health services. Accurate and timely claims and encounter data submission and use of appropriate CPT and diagnosis codes are of paramount importance for the accuracy of these measures. The hybrid methodology consists of both administrative data and a sample of medical records. It requires review of a random sample of members' medical records to abstract data for services rendered that are not reported through claims or encounter data. Measures typically requiring medical record review include diabetic HbA1c, eye exam, and controlling high-blood pressure.

16.3 Quality of Care Concerns

Quality of care concerns may be reported by both internal and external customers such as members, providers, and advocates. All reported concerns are investigated and monitored for trends.

In the event a quality-of-care concern is reported, SECUR requires full cooperation with the investigation of the concern. This includes the timely submission of requested written response, medical records, and the implementation of corrective action plans, as applicable. Providers have the right to respond to reported concerns.

For more information regarding quality-of-care concerns, please contact the Quality Improvement Department at 1.833.76SECUR (1.833.767.3287).

16.4 Provider Sanctioning Policy

In the event SECUR identifies healthcare services rendered to a plan member by a participating provider that are outside the recognized treatment patterns of the organized medical community and quality management and/or credentialing standards, the provider may be subject to sanctions. The National Provider Data Bank (NPDB) may be notified of all negative outcomes if

formal sanctioning proceedings are implemented and if the outcome is scheduled to last thirty (30) days or more.

In addition to the above, SECUR will exclude and/or penalize a provider under any of the following conditions:

SECUR has received recommendations to take such action because of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency;

- The provider fails to cooperate with an investigation of alleged fraud and abuse.
- The provider has been listed on the Medicare/Medicaid Sanctions Report.
- Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include limiting a PCP's panel but not necessarily limiting the freezing of new member assignments.
- Termination of participating provider status.
- Withholds from future claims payments of amounts that are improperly paid or reasonable estimates of such amounts.
- Suspension of claims activity.

Appendix 1: Definitions

All capitalized but not otherwise defined terms shall have the meanings ascribed to such items in the applicable agreement.

ABUSE — actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

ACCREDITATION ORGANIZATION — any organization engaged in the business of accrediting or certifying health maintenance organizations that accredit SECUR.

ADVERSE or UNTOWARD INCIDENT — an event, as defined in Section 458.351, Florida Statutes, over which provider or hospital could exercise control, which is more probably associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical intervention occurred, and which results in one of the following:

- Death
- Brain or spinal damage
- Performance of a surgical procedure on the wrong patient
- Performance of a wrong-site surgical procedure
- Performance of a wrong surgical procedure; or
 - The surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed-consent process if it results in: death, brain, or spinal damage; permanent disfigurement not to include the incision scar; fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory function; or any condition that required the transfer of the patient.
- Procedure to remove unplanned foreign objects remaining from a surgical procedure.
- Any condition that required the transfer of a patient to a hospital licensed under chapter 395 from an ambulatory surgical center licensed under chapter 395 or any facility or any office maintained by a physician for the practice of medicine which is not licensed under chapter 395.

ADMITTING PANEL PHYSICIAN — a provider who is responsible for admitting a member to a hospital or other inpatient health facility on behalf of the member's primary care physician.

AGREEMENT — that certain agreement entered by and between provider and SECUR or between hospital and SECUR pursuant to which provider and hospital shall render provider services or hospital services to members, as applicable, and all amendments thereto.

ALLOWANCE — the allowance shall be the pre-negotiated amount provider or hospital agreed to accept for covered services under the agreement for members enrolled in the (i) SECUR Medicare Plan for Preferred Provider Organization Benefit Program; (ii) SECUR Medicare Plan for Point of Service Benefit Program, solely for the out-of-network component of such Benefit Program; or (iii) other Benefit Program, as SECUR may determine, at SECUR's sole discretion under the applicable SECUR Medicare Plan.

AUDIT — a process conducted by SECUR and/or its designee to determine whether data in hospital's records and/or policies and procedures supports those services listed on hospital's

bill for services provided to a member and whether the claim was properly paid considering such data.

BILLED CHARGES — Provider's or hospital's usual and customary rate for a particular service provided to members in effect on the effective date.

CAPITATION FEE — the fixed amount per member per month provider receives from SECUR to provide provider services, as specifically set forth in the agreement, if any, adjusted by a percentage of the actuarial value of benefit changes to the applicable members' SECUR Medicare Plan, as determined by SECUR and modified from time to time at SECUR's sole discretion or as otherwise required by law.

CLAIM — (i) for non-institutional providers, a paper or electronic instrument submitted to SECUR in accordance with the agreement that consists of the CMS-1500 data set, or its successor, that has all mandatory entries for a physician licensed according to Florida Statutes or psychologists licensed under Florida Statutes or any appropriate billing instrument that has all mandatory entries for any other non-institutional provider; and (ii) for institutional providers or hospitals, a paper or electronic billing instrument submitted to SECUR in accordance with the Agreement that consists of the CMS-1450 (formerly UB-04) data set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee. Notwithstanding the foregoing, all electronic claims must be submitted by providers and hospitals in accordance with HIPAA transaction code set requirements, as may be amended from time to time, and SECUR's companion guide to HIPAA transactions, as set forth in this manual and required in accordance with HIPAA.

CLEAN CLAIM — a claim submitted by provider or hospital that has no defect, impropriety, or circumstance requiring special treatment that prevents timely payment. In the event SECUR requires additional substantiating documentation, including medical records or encounter data from a source outside of SECUR, the claim shall be deemed a non-clean claim.

DENIED CLAIM — a claim that has been received and processed by the payer, but a negative determination was made.

REJECTED CLAIM — a claim that is not forwarded to the payer due to errors or missing information.

COINSURANCE — upon satisfaction of the applicable deductible, the percentage of the allowance not paid or payable by SECUR, which percentage is the responsibility of the member, and which is exclusive of all amounts due for deductibles, copayments, benefit reductions, non-covered services, and charges more than the allowance. The benefit payable by SECUR on behalf of a member under his/her SECUR Medicare Plan is the applicable percentage of the allowance, subject to all deductibles, copayments, coinsurance, penalties, and other charges provided for in the applicable SECUR Medicare Plan.

COPAYMENTS — charges pursuant to a SECUR Medicare Plan that are required to be paid by a member directly to provider or to hospital or a covering physician at the time covered services are rendered, in accordance with the schedule of benefits applicable to the SECUR's Medicare Plan.

COVERED SERVICES — all physician, medical and hospital services, benefits, and supplies, including, without limitation, primary care services, specialist services, emergency services, and urgently needed services, that SECUR is obligated to provide coverage for members under the terms of the applicable SECUR Medicare Plan and this manual.

COVERING PHYSICIAN — a provider who (i) is a duly licensed doctor of medicine or osteopathy under the laws of the State of Florida; (ii) entered into an agreement, either oral or written, with provider to provide covered services to members when provider is not available; and (iii) is a provider or locum tenens provider. A covering physician must meet the “covering physician” requirements set forth in this manual and shall be required by the provider to abide by all terms and conditions of the agreement and this manual. A covering physician may include an admitting panel physician or a hospitalist physician.

CREDENTIALING CRITERIA — the protocol for the process performed by SECUR or its designee to verify that a provider or hospital satisfies SECUR’s requirements for participation in its provider network, including, but not limited to licensure, certification, and any other requirements and/or standards adopted by SECUR regarding providers’ and hospitals’ qualifications. Credentialing criteria shall include protocols for the recredentialing process of providers and hospitals with such frequency as SECUR may elect.

DEDUCTIBLE — the number of charges for covered services applied against the relevant allowance that a member must pay in each calendar year before SECUR will reimburse or pay for covered services.

DELEGATE — a business relationship between the Medicare Advantage Organization and a first-tier entity to perform certain contractually mandated functions that otherwise would be the responsibility of the Medicare Advantage Organization to perform under its contract with the CMS:

Downstream Entity — any party that enters a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First-Tier Entity — any party that enters a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare-eligible individual under the MA program or Part D program.

Related Entity — any entity that is related to an MAO or Part D sponsor by common ownership or control and:

- (1) Performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation.
- (2) Furnishes services to Medicare enrollees under an oral or written agreement.
- (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than \$2,500 during a contract period.

EFFECTIVE DATE — the date that the agreement is deemed effective as set forth in the agreement.

ELIGIBILITY INFORMATION — information provided by SECUR to providers and hospitals regarding the eligibility status of an individual for coverage under a SECUR Medicare Plan.

EMERGENCY MEDICAL CONDITION — (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms,

such that a prudent layperson, pursuant to section 4704 of the 1997 Balanced Budget Act, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- (1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.
- (4) With respect to a pregnant woman:
 - (a) That there is inadequate time to effect safe transfer to another hospital prior to delivery.
 - (b) That a transfer may pose a threat to the health and safety of the patient or fetus.
 - (c) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES — medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists, and if it does, the care, treatment, or surgery for a member by a physician, which is necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

ENCOUNTER DATA — documentation provided to SECUR by providers and hospitals on a monthly basis that summarizes all relevant information that pertains to any occasion where a member receives covered services, including all data necessary to characterize the context and purpose of each encounter between a member and provider, facility, physician or other practitioner, such as the member identification number, provider identification number, date of service, applicable CPT4 and ICD10 codes, place of service and provider's usual and customary charge for the service rendered. Encounter data shall comply with applicable accreditation organization standards, laws, and regulations in effect sometimes, and shall be on such forms and provided with such frequency as SECUR may require.

FRAUD — knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

HIPAA — the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and particularly Title II, Subtitle F (Administrative Simplification) thereof (42 U.S.C. §§ 1171 *et. seq.*) and all applicable regulations, as amended from time to time.

HOSPITALIST PHYSICIAN — Physicians contracted, directly or indirectly, with SECUR who are responsible for certain primary care services, which PCP is otherwise obligated to provide under the agreement on behalf of PCP members who present to or are admitted as inpatients to a hospital, as set forth in this manual and in accordance with the agreement.

HOSPITAL VENDOR — any and all individuals or entities contracted with the hospital to provide hospital services.

LOCUM TENENS PROVIDER — a licensed physician who provides provider services to members on a temporary basis when neither the provider nor the covering physician is readily available to provide care to members.

MEDICAL DIRECTOR — Physician(s), or his/her designer(s), who is designated by SECUR to review the provision of covered services to members and perform certain administrative duties.

MEDICAL INTERVENTION — actions of a provider or hospital in providing healthcare services.

MEDICARE — the Medicare Advantage Program provided under Title XVIII of the Social Security Act, as amended.

MEMBER — a Medicare-eligible beneficiary who is enrolled as a member under a SECUR Medicare Plan.

NON-CLEAN CLAIM — a claim that has a defect due to missing key data, such as procedure, diagnosis, or provider information that prohibits the claim from being processed.

NON-PARTICIPATING PROVIDER — a healthcare provider including, but not limited to, physicians, physician's assistants, osteopaths, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners (ARNP), midwives and nurse midwives, hospitals, and other healthcare facilities that is **not** under contract, directly or indirectly, with SECUR to provide covered services to members.

PARTICIPATING PROVIDER — a healthcare provider including, but not limited to, physicians, physician's assistants, osteopaths, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners, midwives and nurse midwives, hospitals, and other healthcare facilities that **is under contract**, directly or indirectly, with SECUR to provide covered services to members.

PRIOR AUTHORIZATION — an authorization that must be obtained from SECUR or its designee, prior to the provision of certain covered services, as set forth in this manual and as required by the applicable SECUR Medicare Plan and the agreement.

PRIMARY CARE PHYSICIAN/PCP — a doctor of medicine or osteopathy who is a family practitioner, general practitioner, internist, or other practitioner as permitted under state law, licensed by the State of Florida, and who entered into a written agreement with SECUR to provide primary care services to members.

PRIMARY CARE SERVICES — the services listed below, which PCP is required to provide in accordance with and subject to the agreement, this manual and the applicable SECUR Medicare Plan:

- A. **Primary Care Covered Services** including, but not limited to, all services, tests, supplies, and procedures dictated by the need for preventive, diagnostic, or therapeutic care for the treatment of a particular injury, illness, condition, or disease that does not require the knowledge, skill, or expertise of a specialist, including, but not limited to, those which are provided in PCP's office, a member's home, a hospital, a nursing home, or elsewhere.
- B. **Vision and Hearing Screening** excluding refraction for vision correction prescription.

- C . **Family Planning Services** including, but not limited to, counseling with respect to birth control and contraception, or assistance to determine the cause(s) of infertility.
- D . **Appropriate Referral Services** to providers, including specialists, for services of a non-primary care nature including, but not limited to, orthopedics, ophthalmology, urology, neurology, gastroenterology, surgery, obstetrics and gynecology, otolaryngology, dermatology, cardiology, and psychiatry.
- E . **Administrative Services** including, but not limited to, arranging, coordinating, and managing the delivery of covered services that are not primary care services to members and the performance of administrative functions in connection therewith in accordance with the agreement and this manual and as required by the applicable SECUR Medicare Plan.

PROVIDER — a healthcare provider including, but not limited to, physicians, including primary care physicians and specialists, physician assistants, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners, midwives and nurse midwives, and other healthcare facilities that are under contract, directly or indirectly, with SECUR to provide covered services to members. The term “provider” shall not include hospitals, unless specifically indicated herein.

PROVIDER SERVICES — those covered services provider typically provides to all their patients, including but not limited to primary care services, as applicable, which provider is required to provide in accordance with and subject to the agreement, this manual and the applicable SECUR Medicare Plan.

PROVIDER STAFF — all physicians, administrative staff or other healthcare professionals employed by or associated or contracted with the provider, as set forth in the agreement.

REFERRAL/REFER — recommendation of a member to a provider that may or may not require prior approval by SECUR in accordance with this manual and as required by the applicable SECUR Medicare Plan.

RISK MANAGEMENT — the identification, investigation, analysis, and evaluation of risk and the solicitation of the most advantageous methods of correcting, reducing, or eliminating identifiable risks.

SERVICE AREA — the area consisting of those Florida counties for which SECUR has regulatory approval to provide services pursuant to its license requirements of the Florida Statutes and under its contract with CMS, as amended by SECUR from time to time at its sole discretion.

SICK CARE — non-urgent problems that do not restrict normal activity but could develop complications if left untreated (e.g., chronic disease).

SPECIALIST — a physician licensed to practice medicine by the State of Florida (other than a primary care physician) who entered into a written agreement with SECUR, either directly or indirectly, to provide specialist services to members pursuant to a referral or prior authorization from a primary care physician.

SPECIALIST SERVICES — those covered services a specialist is contracted to provide, as specifically set forth in their agreement.

SUBSCRIBER GROUP — any public or private organization, firm, association, business, employer group, or other entity that entered a SECUR Medicare Plan for the provision of healthcare services to its constituents.

SECUR MEDICARE PLAN — an agreement, contract, or undertaking pursuant to which SECUR arranges for the provision of certain healthcare services to members in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the regulations and guidance promulgated thereunder, as amended from time to time, and SECUR's contract with CMS.

URGENTLY NEEDED SERVICES/URGENT CARE — covered services for conditions that (i) though not life-threatening, could result in serious injury or disability to the member unless medical attention is received or (ii) substantially restrict a member's activity; and (iii) which are provided (a) when a member is temporarily absent from the service area or; (b) under unusual and extraordinary circumstances, when the member is in the service area but all providers are temporarily unavailable or inaccessible when such covered services are medically necessary (as defined under Medicaid) and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the covered services through a provider. Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu, and respiratory ailments.

WASTE — the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is not considered to be caused by criminally negligent actions but by misuse of resources.

WELL CARE — a routine medical visit for one of the following: child health check-up visit, family planning, routine follow up to a previously treated condition or illness, adult physicals, and any other routine visit for other than the treatment of an illness.

WELL WOMAN VISIT — an annual medical visit to a gynecologist by a female member for the purpose of assessing her reproductive health.

Appendix 2: Acronyms

Commonly Used SECUR, Inc. Acronyms	
AAAHC	American Association for Ambulatory Healthcare
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Centers
C.F.R.	Code of Federal Regulation
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
C-SNP	Chronic Condition Special Needs Plan
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DOH (DH)	Department of Health
DRG	Diagnosis Related Group
D-SNP	Dual Eligible Special Needs Plan
EDI	Electronic Data Interchange
FTE	Full-Time Equivalent (Physician)
HCPCS	Healthcare Common Procedure Coding System
HEDIS™	Health Plan Effectiveness Data Information Set
HIPAA	Health Insurance Portability and Accountability
HRA	Health Risk Assessment
ICD	International Classification of Diseases
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
MOC	Model of Care
NCQA	National Committee for Quality Assurance
OIR	Office of Insurance Regulation
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
QIO	Quality Improvement Organization
PA	Physician Assistant
PCP	Primary Care Physician
PQI	Potential Quality of Care Issue
PT	Physical Therapy
QDWI	Qualified Disabled Working Individuals
QI-1	Qualified Individual
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low Income Medicare Beneficiary
SNF	Skilled Nursing Facility
ST	Speech Therapy
UM	Utilization Management

Commonly Used SECUR, Inc. Acronyms	
USC	U.S. Code

Appendix 3: Sample Forms Section

Sample Record Request Form:

Record Request Form

Confidential

Date: MM/DD/CCYY

Member Name: Jane

Doe Member Id: Z222944444301

Age: 72

PCP Name: John Smith

Member LOB: MCR

Previous Diagnoses:

554.32 Diabetes (ICD-10 codes for the past three years)

Health Screening Information: According to our records, these preventive and chronic care tests or procedures have not been completed.

Test Needing Review	Action/Signature
Colorectal Screening Testing	

Sample Request for Prior Approval for In-Network Provider Form



REQUEST FOR PRIOR APPROVAL FOR IN NETWORK PROVIDER

FAX Form and Clinical to SECUR Utilization Management Fax: 833.852.3607

***** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY*****

<p>*PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER. Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage.</p>	
Member Data	<p>Member Name _____ Date of Birth _____ Member's Plan ID _____</p> <p>Name of Nursing Facility _____ Referring Provider _____</p> <p>Diagnoses (ICD-10 Codes) Related to Auth Request _____</p>
Service	<p>Date of Procedure/Service: _____ CPT Code or Name of Procedure/Service: _____</p>
<p>SERVICES REQUESTED (include copy of order and the clinical notes)</p>	
Specialist/Ancillary Provider/Facility	<p>Provider Name (REQUIRED): _____</p> <p>Provider Contact Number (REQUIRED): _____</p> <p>Provider Specialty (REQUIRED): _____</p> <p>In Network (REQUIRED): <input type="checkbox"/> Yes <input type="checkbox"/> No Provider NPI: _____</p>
Requesting Provider	<p>1. Is this member new enrollee with the Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has this provider seen this member in the last 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Has the service been scheduled already: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is this a specialized service that no other provider can render: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Does the member have an established relationship with the provider that should not be interrupted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Explain: _____</p>
<p>TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION</p>	
<p>Name of Person Completing this Form: _____ Date Completed: _____</p> <p style="text-align: center;">(Please Print Name)</p> <p>Contact #: _____ Contact FAX: _____</p>	

00N Request Form 1

Sample Incident Report



INCIDENT REPORT			
PRIVILEGED AND CONFIDENTIAL Complete every field/space on this report and send to Risk Manager			
MEMBER INFORMATION			
Name			Member ID#
DOB	Gender		
Initial Diagnosis	Initial ICD-10 Code		
Incident Date	Incident Time AM / PM		
Incident Location			
Facility Name (If In-patient)			
Admission	Date	Time	Admitting Dx & ICD – 10
Was a Physician called?	YES	NO	
Name of Physician called			
PCP Name (or attending if In-patient)			
Name of Specialist involved			
Recommendations of Physician(s)			
Names of Witness (es)			
Witness (es) location information			
Physical Findings / Dx			
INCIDENT DESCRIPTION			
Give a clear concise description of the incident including time, date, and exact location where it occurred, as well as type, location, and extent of injury. <i>(Attach extra sheet of paper if more space is needed)</i>			
Final Dx ICD – 10 Code(s)			
Report Prepared By <i>(Print Name)</i>			Title
Signature		Date & Time Prepared	
Fax to Risk Manager at 813.357.5352 WITHIN THREE WORKING DAYS.			

INCIDENT REPORT PRIVILEGED AND CONFIDENTIAL

Definition

An adverse incident is an event over which the healthcare personnel could exercise control, and which could or did result in injury to a member. Examples of adverse incidents include, but are not limited to:

- Death or injury caused by the healthcare rendered, or failure to render, and not caused by the member's medical condition (including brain or spinal injury).
- Suicide of a patient in a setting with round-the-clock care.
- Equipment failure or malfunction.
- Surgery on the wrong member, wrong site.
- Surgery unrelated to the member's diagnosis or condition or medical need.
- Surgical repair of damage resulting from a planned surgery, where the damage is not a recognized specific risk, as disclosed to the member and documented through the informed consent process.
- Surgery to remove unplanned foreign objects remaining from a surgical procedure.
- Medication error (wrong member or medication or dose or route).

SECUR considers the following occurrences "reportable incident" under the adverse incident reporting requirements:

- Infant/child abduction or discharge to wrong family.
- Allegations of inappropriate sexual contact/comment involving a healthcare provider.
- Allegations of physical assault, abuse, or battery.
- Allegation of discrimination.
- Allegation of fraud.

Adverse Incidents are documented by completing an **incident report** form and delivering it to SECUR's risk manager within three (3) calendar days. Incident reports are part of risk management files **only** and copies of incident reports must be maintained separately from member's medical records.

All incident reports will be reviewed, and date stamped upon receipt and appropriate action initiated when indicated, but no written response from the member or other party involved is usually required. Incident reports will not be used to penalize providers. However, failure to report an incident may be cause for disciplinary action by SECUR.

SECUR's risk manager has access to the provider's medical records and incident reports for risk management investigations. Providers shall submit such medical records and other records without charge, within ten (10) days of receipt of written notice. Failure to comply and the applicable policies may be deemed a material breach of contract (Provider Service Agreement).

**INCIDENT REPORT
PRIVILEGED AND CONFIDENTIAL**

When an incident occurs:

1. Complete the *incident report* form immediately when becoming aware of an adverse incident or reportable event.
2. Fill each blank on the form, using N/A when something is not applicable to the occurrence.
3. Write legibly or type the information on the form.
4. Describe the incident carefully. Be brief, but include important information, including: who, what, where, when, how?
5. Indicate the body part injured, location and extent of injury and document fully, including lack of injury.
6. Report any pertinent action taken in response to the occurrence.
7. Obtain the name and locating information of any witnesses, including employees.
8. Sign and date the report. Include title/designation and contact number.
9. Submit Incident Report to supervisor for review and, if indicated, coordination of immediate research.
10. Fax to 813.357.5352 ATTN: Risk Manager, in confidence.

For assistance in completing the incident report form, contact SECUR's risk manager at 1.833.76SECUR (833.767.3287).

Request for Medicare Prescription Drug Coverage Determination

Use the following link to submit an electronic **Medicare Prescription Coverage Determination** or fax to 1.855.668.8552.

Request for Redetermination of Medicare Prescription Drug Denial

Use the following link to submit an electronic **Redetermination of Medicare Prescription Drug Denial** or fax to 1.844.268.9791.

Sample Waiver of Liability Statement Form

Waiver of Liability Statement

Enrollee's Name

Enrollee ID Number

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date

Disease and Case Management Referral



DISEASE AND CASE MANAGEMENT REFERRAL

FAX Form to SECUR Health Plan: 833.852.3607

***** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY*****

MEMBER INFORMATION	
Member Name	
Date of Birth	Member's Plan ID
Name of Nursing Facility	Referring Provider
Referring Provider	<input type="checkbox"/> Plan NP <input type="checkbox"/> PCP <input type="checkbox"/> Plan PA <input type="checkbox"/> Other
Diagnoses (ICD-10 Codes)	
PROVIDER INFORMATION	
Provider Name	Provider Contact Number
Specialist Name	Fax
<p>Please check the Disease and Case Management Program, you wish the member to be evaluated for participation:</p> <p><input type="checkbox"/> Alcohol and Drug Dependence <input type="checkbox"/> Autoimmune Disorders Cancer <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Chronic Lung Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> End-stage Liver Disease <input type="checkbox"/> End-stage Renal Disease <input type="checkbox"/> Mental Health Disorder <input type="checkbox"/> Neurologic Disorder <input type="checkbox"/> Severe Hematologic Disorder <input type="checkbox"/> Stroke</p> <p>Please provide pertinent medical information and any details about current status of member.</p>	
FOR DISEASE AND CASE MANAGEMENT USE ONLY	
Date Received	Date Evaluated
Disease Management Determination <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	
Comments	
Name of Case Manager	Date