PeakHealth

2023

Provider Manual

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Section 1 – Overview

Welcome

Thank you for your decision to participate with Peak Health and to support our mission in making healthcare more accessible, understandable, and collaborative. Peak Health is a provider-led health plan created to help West Virginians, and our members in the surrounding areas we serve, enjoy healthier and fuller lives. The Participating Provider Manual was developed as a resource for understanding how we can work efficiently together to improve the lives of West Virginians. The Peak Health Participating Provider Manual includes, but is not limited to, information such as:

- Services offered providers and members
- Requirements for participation in our provider networks
- Administrative requirements and guidelines
- Claim submission guidelines for quick and accurate processing

This manual is intended to be a key resource for all Peak Health participating providers.

About Peak Health

Founded in 2021, Peak Health is an insurance services company headquartered in Morgantown, WV and built for West Virginians by West Virginians. WVU Medicine is joining forces with Mountain Health and Marshall Health to create a comprehensive system that allows us to focus on improving the health of a patient and lowering the cost of care. Peak Health will offer inclusive, provider-led health plans that help West Virginians live healthier and fuller lives. Our health plan administration will feature a network of WVU Medicine providers with a national wrap network administered by First Health, an Aetna company.

Our mission is to make healthcare more accessible, understandable, and collaborative. We created Peak to address what we see as a frustrating lack of progress in helping West Virginians lead healthier and fuller lives. Peak is a reflection of who we are, our beliefs, and our long-term commitment to the state. We believe that by working together we can build a health plan that is better for our employees and for all West Virginians. For more information, visit peakhealth.org

Contact Information

For more information please contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325), Monday through Friday, 8:00am to 5:00pm ET, excluding holidays.

Section 2 – Claims Procedures

Checking Member Eligibility

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to the service date. Member eligibility can be verified through one of the methods listed below.

Online:

- Visit Peak Health Provider Login to access the PeakProvider secure portal

Phone:

- Call Peak Health Provider Service at 1-833-969-7325 (1-833-9-MYPEAK) or the number listed on the back of the patient's member ID card.
- Provide the subscriber's identification number and other authentication information.

Electronically:

- Eligibility can be checked via a standard 270/271 EDI transaction.

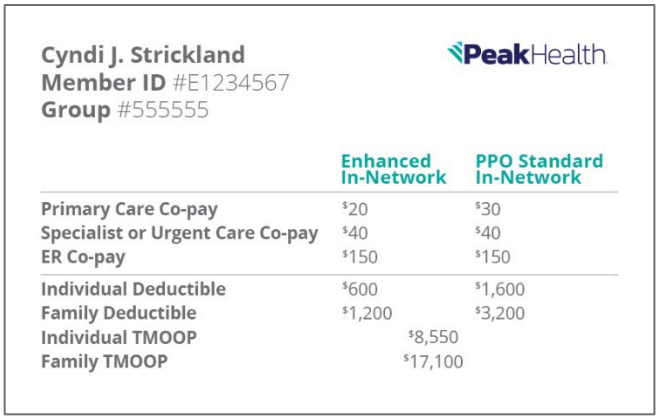
The member ID card bears the name and logo of the insurance company or plan administrator to contact for benefit verification and eligibility. The verification phone number and/or website address can be found on the member ID card.

Member Identification Card

Member identification cards may be accessed electronically on MyChart and contains information regarding a member's name, group number, deductibles, copayments, and Out of Pocket amounts. Network provider search options along with Peak Health contact information is included on the back of the member identification card. As a participating provider, it is your responsibility to verify member eligibility and to request a copy of the member's card. On all subsequent visits, the provider should inquire if the patient has had any change in health insurance because incorrect information can result in delayed payment of a claim.

Members have been issued member identification numbers that are assigned by Peak Health. The ID base length is 8 numeric characters. The generated number is based on the ID base plus an assigned suffix value. Dependents and Subscriber ID base is the same, and the following are the set suffixes for members: Subscriber-01, Spouse-02, Initial Dependent Suffix- 03, etc. A member identification number is used to protect a member's privacy in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations. Key information is identified on the sample identification card below.

> **Note:** To avoid potential issues with identity theft or fraud, ask the patient for a separate form of identification (i.e. driver's license) in addition to the member ID card.



When applicable, a copayment is collected from the patient at the time of service. Copayment amounts are listed on the member's ID card. Because copayments are subject to change, please verify the amounts via the PeakProvider Secure Portal at Peak Health Provider Login or the number listed on the back of the member's identification card.

Providers should have a timely process in place to refund patients any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when the claim is processed by Peak Health.

Medical Policies

Medical Policies are documents that provide medical necessity and clinical guidelines. These guidelines address medical issues such as diagnostic and therapeutic procedures, injectable drugs, and durable medical equipment. Peak Health clinical guidelines have been integrated into the claims processing system, to allow for cost-effective processing of claims and to ensure accurate administration of member healthcare benefits.

Peak Health utilizes InterQual medical necessity criteria to guide utilization management evidence-based care philosophy. In cases where InterQual does not provide medical necessity criteria for procedural codes, Peak Health provides a policy.

Peak Health Medical Policies can be found at peakhealth.org

Claims Submission and Processing Guidelines

Filing Methods

Unless applicable law provides that claim submissions can be in paper format, providers must submit all claims, encounters, and clinical data to Peak Health electronically (EDI). Electronic means accepted as industry standard and may include claims clearinghouses or electronic data interface (EDI) companies used by Peak Health. Providers using electronic submission must submit all claims to Peak Health or its designee, as applicable, using the HIPAA-compliant 837 electronic format using the electronic payor ID: Peak0 (numeric not alpha O). When the 837 standard electronic format requires the submission of a taxonomy code from one or more providers, a taxonomy code must be submitted for each provider, and the taxonomy code must be the code most appropriate for that provider and the services provided.

Peak Health requires all contracted providers that have the ability, to submit claims electronically through their clearinghouse Electronic Data Exchange (EDI). If your clearinghouse is not set up with Peak's payer ID, providers should reach out to their clearinghouse or patient accounting software vendor to request an electronic claim connection for Peak Health. Please note, some clearinghouses use their own unique payer ID, so please confirm you, as a provider, are using the correct payer ID according to your clearinghouse's payer ID list.

If the provider clearinghouse does not have an active connection to Peak Health for electronic claims, providers should follow their normal support process with their clearinghouse to request the connection to be established. The provider clearinghouse has multiple connection options for setting up the payer ID. Peak Health electronic claims do not require enrollment.

Peak Health 835 remittances do require enrollment. Providers should request the 835-enrollment using the same support process as the electronic claims. The provider clearinghouse must be included in the 835 enrollments, so they are aware those files need to be delivered back to their provider's sftp.

Peak only accepts paper claims for processing from providers under the following conditions:

- You are not a contracted provider with Peak
- You have no EDI capability at your practice

If you do not fall into one of the above scenarios, EDI submission for all claims is required.

When submission of a paper format is permissible, providers must submit claims using an original CMS-1500 and/or an original UB-04 form, or their successors. Photocopies or outdated versions of the forms will be returned to the provider and will need to be resubmitted on the appropriate form.

Paper claims should be submitted to the address listed on the back of the member's ID card as shown below:

Peak Health, Medical Claims
PO Box 4678
Morgantown, WV 26504-4678

Timely Filing: Any claims will be denied for untimeliness unless submitted and received within 365 days from Date of Service or as specified in your Participating Provider Agreement. This applies to both professional and hospital/facility claims.

Inpatient Specialty Services: Depending on the type of plan, claims for inpatient treatment may require an inpatient authorization number. If the inpatient authorization number is not on the claim, the claim may be rejected. The member may not be balance billed for this type of rejected claim.

Claims Processing Procedures: Peak Health processes accurate and complete provider claims in accordance with Peak Health's standard claims processing procedures, including, but not limited to, claims processing edits and claims payment policies, and applicable state and/or federal laws, rules, and regulations.

Peak Health develops claims processing procedures based on review of one or more of the following sources, including, but not limited to:

- Medicare laws, regulations, manuals, and other related guidance
- Federal and state laws, rules, and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services CMS' Healthcare Common Procedure Coding System (HCPCS) and associated
- CMS publications and services
- International Classification of Diseases (ICD)

- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance \ Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Peak Health medical and pharmacy coverage policies

Claim Form Requirements

CMS/HCFA 1500 Forms: These forms are for professional services performed in a provider's office, hospital, or ancillary facility on an outpatient basis. Custom provider specific forms are not acceptable and will be returned if submitted. The required fields on these forms are listed below.

1. The type of insurance and the insured's ID number
2. The patient's full name
3. The patient's date of birth
4. The insured's full name, if applicable
5. The patient's address
6. The patient's relationship to the insured, if applicable
7. The insured's address, if applicable
8. Field reserved for NUCC use
9. The name of another insured's name, if applicable and different from box 2
10. What the patient's condition is related to
11. The insured's policy or group number
12. The patient's signature
13. Whether the patient's or insured's signature is on file or not
14. The date of the current illness
15. Another date related to the condition, if applicable
16. The dates the patient has been unable to work because of the condition
17. The name of the referring provider, if applicable
18. Hospitalization dates related to the treatment
19. Additional claim information
20. Further additional claim information, if applicable
21. The diagnosis
22. Prior resubmission code, if applicable
23. Prior authorization number, if applicable
24. Applicable codes relating to the date of service, place of service, emergency indicator and procedures, charges, and number of medical visits
25. Federal Tax Identification number
26. The patient's account number
27. Where the check should be sent
28. Total charges for the procedure
29. The amount paid
30. Field reserved for NUCC use
31. The signature of the physician, including their degrees or credentials
32. The name and address of the location where services were rendered and NPI number
33. The billing provider's information, address, phone number and NPI number

UB04 Forms: These forms are for inpatient services or ancillary services performed in a hospital. The UB92 form is no longer accepted in accordance with Medicare guidelines. The UB04 is the revision to the UB92, with

changes including the addition of field to input a National Provider Identifier (NPI) and additional fields for items such as more diagnosis codes. The required fields on these forms are listed below.

1.Enter the name and payment address of the hospital/provider.
2. Enter the address of the payee if different from the address in Box #1.
3. a-b Patient Control Number
** 3a: Enter the patient account number as assigned by the hospital.
** 3b: Enter the medical record number
4. Enter the 3-digit code to indicate the type of bill submitted.
5. Enter the hospital/provider's federal tax ID number.
6. Statement Covers Period
** Enter the beginning and ending services dates for the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the FROM and THROUGH dates will be the same.
** If the FROM and THROUGH dates differ, (Peak Health requires these services to be itemized by date of service (refer to Box #45).
7. Not applicable.
8. a-b Patient Name
** 8a: Enter patient ID number.
** 8b: Enter the patient's last name, first name and middle initial, if any, as shown on the patient's ID card.
9. Enter the patient's mailing address from the patient record.
10. Enter the patient's date of birth (MMDDYY).
11. Enter M or F.
12. Enter the date of this admission/visit.
13. Enter the time of this admission/visit.
14. Enter the code indicating the type of this admission/visit.
15. Enter the code indicating the source of this admission/visit.
16. Enter the time the patient was discharged.
17. Enter the code to indicate the status of the patient as of the THROUGH date on this billing (Box #6).
18-28. Condition Codes - Enter the code used to identify conditions relating to this bill that can affect payer processing.
29. Accident (ACDT) State - Enter the state in which an auto accident occurred, if applicable.
30. Untitled, not applicable.
31-34. Occurrence Codes and Dates - Enter the code and associated date defining a significant event relating to this bill that may affect payer processing.
35-36. Enter a code and the associated dates that identify an event that relates to the payment of the claim.
37. Untitled, not applicable.
38. Untitled, not applicable.
39-41. Value Codes and Amounts, not applicable.
42. Revenue (REV) Codes - Enter the most current uniform billing revenue codes.
43. Revenue Description
** Enter a narrative description of the services/procedures rendered.
** Whenever possible, use CPT-4/HCPCS definitions.
44. HCPCS/Rates
** For outpatient services, use CPT and HCPCS Level II codes for procedures, services, and supplies.
** Do not use unlisted codes. If unlisted codes are used, supporting documentation must accompany the claim.
45. Enter the date the indicated service was provided.
46. Enter the units of service rendered per procedure.
47. Enter the charge amount for each reported line item.
48. Enter any non-covered charges for the primary payer pertaining to the revenue code.

49. Untitled, not applicable.
50 A-C Payer Name
** List all other health insurance carriers on file.
** If applicable, attach an EOB from other carriers.
51. Health Plan ID, List the provider number assigned by the health insurer carrier.
52. Release of Information (REL INFO), not applicable.
53. Assignment of Benefits (ASG BEN), not applicable.
54. Prior Payments (payer and patient)
** Report all prior payment for the claim.
** Attach EOB from another carrier, if applicable.
55. Est. Amount Due, not applicable.
56. NPI, Enter valid NPI number of the servicing provider.
57 A-C , Other Provider (PRV) I, not applicable.
58 A-C, Insured's Name - Enter the name of the individual carrying the insurance.
59 A-C, Patient's Relationship to the Insured (P REL) - Enter the code indicating the relationship of the patient to the identified insured/subscriber.
60 A-C, Insured's Unique ID - Enter the patient's identification number as it appears on the identification card.
61 A-C Group Name - Enter the name of the group or plan through which the insurance is provided to the insured.
62. Insurance Group Number - Enter the group number to identify the group under which the individual is covered.
63. A-C Treatment Authorization Code
64. Document Control Number, not applicable.
65. Employer Name, Enter the name of the employer for the individual identified in Box #58, if applicable.
66. DX Version Qualifier, not applicable.
67. A-Q, Principal Diagnosis Code
** Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for causing this admission/visit. The code must be to the appropriate digit specification, if applicable.
** If the diagnosis is accident-related, then an occurrence code and accident date are required.
** The POA indicator is the 8th digit of the Field Locator and the 8th digit of each of the Secondary Diagnosis fields, ** Report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the 8th digit.
** Leave this field blank if the diagnosis is exempt from POA reporting.
68. Other Diagnosis Codes
** Enter the ICD-CM-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently.
** If applicable, the code must be to the appropriate digit specification.
69. Admit DX, Enter the ICD-CM-CM diagnosis code provided at the time of admission and as stated by the physician.
70. Patient Reason DX, Optional.
71. PPS (Prospective Payment System) Code Optional.
72. ECI (External Cause of Injury) Code Enter the ICD-CM-CM code for the external cause of an injury, poisoning, or adverse effect.
73. Untitled, not applicable.
74. A-E, Principal Procedure Code (code and date)
** Enter the most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for the service billed.
** Also enter the date the procedure was performed. The date must be entered as month and day (MMDD).
75. Untitled, not applicable.
76. Enter the ordering physician's NPI, physician's last name, first name and middle initial.

77. Enter the name and NPI number of the physician who performed the principal procedure, if applicable.
78-79. Other Provider Types, Optional.
80. Remarks, not applicable.
81. A-D, ICC Optional.

Note: No claim is complete for a covered service and/or no reimbursement is due for a covered service unless the provider's performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of the claim.

Codes and Modifiers

Peak providers who are reimbursed for ancillary and professional services agree to accept the network reimbursement, (less member copays, deductibles, and coinsurances), as payment in full for all covered services rendered to Peak Health members. Balance billing to the member is *not permitted* for the difference between the provider charge and contracted reimbursement. Peak's Coverage Policy follows the Centers for Medicare and Medicaid Services (CMS) guidelines whenever appropriate.

Coding Practices Subject to Review:

	Practice	Improper Coding	Proper Coding
Fragmenting	Breaking down a multitask service and coding individual coding for each task of the service or procedure separately	Billing removal foreign body eye 65210 which includes anesthesia, then billing a separate anesthesia for the eye code.	Excision of Malignant lesion includes simple closure. 11600 (simple closure not reported separately)
Unbundling	Reporting Separate codes for a related service or procedure when a single code exists to encompass all the services	Billing for a colonoscopy 45380 which includes biopsy, then billing a separate biopsy cpt code.	Colectomy (with anastomosis) 44140 don't bill the anastomosis separately
Down coding	Selecting two or more lower-level codes to identify a service that could have been billed with a single, higher-level code	Reporting Diabetes without the complications by default can result in down coding	Reporting B20 Aids with all the complications that incur with it
Upcoding	Selecting a code at a higher level that was provided to obtain a higher reimbursement	Billing at 99215 when the level of service was a 99213	Billing a 99215 when the medical decision making is correct for that level of service

Below is a table of commonly used modifiers.

Modifier	Description
22	Increased procedural Services (subject to medical management review and approval for payment)
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the same physician or other qualified health care professional on the same day of the procedure or other service
26	Professional Component
32	Mandated Service
33	Preventative Services
47	Anesthesia by a Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons

63	Procedure performed on infants less that 4kg
66	Surgical Team
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional following initial procedure for a related procedure during the post op period
79	Unrelated Procedure or Service by the Same physician or Other Qualified Health Care Professional During Post op Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon is not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other real-time Interactive Audio-only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a real-time Interactive Audio and Video Telecommunication System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
TC	Modifier TC is used when only the technical component (TC) of a procedure is being billed when certain services combine both the professional and technical portions in one procedure code.

Discontinued Procedure: Modifier 53 is used to indicate a procedure is discontinued by a physician or other qualified health professional. This modifier also provides a means of reporting reduced service without disturbing identification of the basic service. This modifier is an indication for physician services only and may not be reported by facilities. *Reimbursement for discontinued procedures with modifier 53 is reimbursed at 25% of the allowable amount*.

Reduced Services: Modifier 52 is used to indicate a procedure has been reduced by a physician or other qualified health professional from the original intended service(s). This modifier is an indicator a lesser service was performed. *Reimbursement for this reduces service with modifier 52 is reimbursed at 50%.*

Increased Procedural Services: Modifier 22 is used to indicate increased procedural services were required beyond the normal treatment. The use of this modifier will require documented medical support to illustrate the needed additional treatment. *Approval will be based on Medical Management review at Peak and reimbursement will be according to individual contract guidelines.*

Ambulance Claims

Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional. Supporting documentation include comprehensive trip notes having destination and complete patient demographics and signatures.

File the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.

The POP (Point of Pick-up) ZIP Code should be submitted as follows:

- Professional Claims – for CMS-1500 submitters: the POP ZIP code is reported in field 23
- Institutional outpatient Claims – for UB submitters: the Value Code of 'A0' (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field, and billed with the appropriate revenue 54x codes.

Independent Clinical Laboratory Claims

An **Independent Clinical Laboratory** is a freestanding clinical laboratory that is not affiliated with a hospital.

A **Referring Laboratory** is a clinical laboratory that forwards specimens to another clinical laboratory for specific tests that cannot be performed by the referring laboratory.

Independent Clinical Laboratory Eligibility:

- Must be credentialed by Peak Health or Aetna First Health Network on the date of service in order to be eligible for payment.
- Certified as an independent clinical laboratory by CMS based on criteria set forth in the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- Licensed as a clinical laboratory in the state of residence pursuant to state regulations. For laboratories in the state of West Virginia, clinical laboratory licensure and certification is governed by Clinical Laboratory Technician and Scientist Licensure and Certification 64 CSR 57 (90-17517-55157-2022-04-04-13-04-05-184 (wv.gov))

Specimen Referral:

- If an independent clinical laboratory cannot perform a requested test, it may refer the specimen to another laboratory that can perform the test.

- When providing the test results, the referring laboratory must inform the authorized prescriber of the name and address of the testing laboratory.
- The testing laboratory must inform the referring laboratory of each test result within one business day of completing each test.
- The referring and testing laboratories may NOT bill the same procedure performed on the same specimen.
- The independent clinical laboratory may not bill for a service unless it has received a written request to perform that specific service from an authorized prescriber who is treating the member
- Per Chapter 16: 'Claims for referred laboratory services may be made only by suppliers having specialty code 69, i.e., independent clinical laboratories. Claims for referred laboratory services made by other entities will be returned as unable to process. Independent laboratories shall use modifier 90 to identify all referred laboratory services. A claim for a referred laboratory service that does not contain the modifier 90 is returned as unable to process if the claim can otherwise be identified as being for a referred service.'

Required information for specimen referral requests:

- the date of the request
- the name or any other means of identifying the member to be tested
- the name and address of the authorized prescriber
- the name of the specific laboratory tests to be performed
- the frequency for performing each laboratory test (applicable to standing orders only)
- the duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only)
- a statement by the authorized prescriber that such testing is required as part of the member's medical or drug treatment plan (applicable to standing orders only)

Maximum Allowable Fees:

- The Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for independent clinical laboratory services. CLFS Files | CMS
    - The maximum allowable payment for a service is the lowest of the following:
        - (1) the amount listed in the applicable DHCFP fee schedule
        - (2) the independent clinical laboratory's usual and customary fee; or
        - (3) the amount that would be recognized under 42 U.S.C. § 13951(h) for tests performed for a person with Medicare Part B benefits
- The maximum allowable payment is full compensation for the laboratory service and any related administrative or supervisory duties in connection with the service, regardless of where the service was provided.
- An independent clinical laboratory cannot bill for more than its usual and customary fee for a service.

Newborns:

- When we receive notification of the birth of a newborn, they are added as a pending dependent. This allows claims to be submitted, but the claims will pend until the subscriber adds the newborn as a covered dependent. The subscriber (parent) has 30 days to add the child to coverage. If we do not have proof of coverage after 30 days, the claim will be denied.

Non-Covered Services:

- Peak Health does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (i.e., venipunctures, urine, fecal, and sputum samples; Pap smears, cultures;

and swapping and scraping for removal of tissue). The cost for such services is included in the payment for conducting the test and analysis.
- Calculations (for example red cell indices, A/G ratio, creatinine clearance), and ratios calculated as part of a profile
- tests performed for experimental or clinical investigational purposes (e.g., to establish safety and effectiveness), or that are themselves experimental or clinically investigational
- tests performed only for purposes of civil, criminal, administrative, or social service agency investigations, proceedings, or monitoring activities
- tests performed for residential monitoring purposes
- tests performed to establish paternity
- post-mortem examinations

Duplicate Claims: Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Olive or Provider Portal.

Corrective Claims Submission: To submit a corrected claim, resubmission code 7, (Replacement of Prior Claim), should be used to indicate the request of reprocessing an already adjudicated claim with corrections. You may also use code 8, (Void/Cancellation of Prior Claim), paired with code 7 as appropriate.

Late Charges: Late charges for Claims previously filed can be submitted electronically. Providers and Facilities must reference the original Claim number when submitting a corrected electronic Claim. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. Providers should also advise the original Claim# to which the late charges should be added.

Negative Charges: When filing Claims for procedures with negative charges do not include these lines on the Claim. Negative charges could result in an out-of-balance Claim that must be returned to the Provider for additional clarification.

Not Otherwise Classified ("NOC") Codes

When submitting Not Otherwise Classified (NOC) codes follow these guidelines to avoid possible Claim processing delays.

- If the NOC is for a drug, include the drug's name, dosage NDC number and number of units.
- If the NOC is not a drug, include a specific description of the procedure, service, or item.
- If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.
- If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
- If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

Note: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional Claim forms, or locator 43 on facility Claim forms

National Drug Codes (NDC)

All Providers and Facilities are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions, except when administered in an inpatient setting.

Line items will deny if Healthcare Common Procedure Coding System (HCPCS) codes or Current Procedural Terminology (CPT) codes, for drugs administered in a physician office or outpatient facility setting AND do not include the following:
Line items on a Claim regarding drugs administered in a physician office or outpatient facility setting for all drug categories will deny if they do not include the following:

- Applicable HCPCS code or CPT code
- Number of HCPCS code or CPT code units
- The valid 11-digit NDC
- Unit of measure qualifier (F2, GR, ML, UN, ME)
- NDC Units dispensed (must be greater than 0)

Note: Unit of Measurement Requirements

Authorizations

Procedures that require prior authorization must have been authorized prior to the service being performed and billed. To obtain more information about obtaining a prior authorization, visit the Medical Management section in the Provider Manual on https://peakhealth.org/peak-provider/

Claims Status Information

For questions regarding member's benefits, claims, authorizations or eligibility, the Peak Health Provider service center is available to assist. The Provider Service phone number is 1-833-9MY-PEAK (1-833-969-7325), and service hours are Monday through Friday 8:00 AM to 5:00 PM, EST. You can leave a phone mail message after hours, on weekends or holidays. Service will return your call by the next business day.
To provide timely service, we ask that you limit the number of claims questions or enrollment verifications to 5 per call. In addition to contacting us by phone, you can also contact us via message using the Peak Provider Portal.

Reimbursement

Payment terms are defined in the provider participation agreement. Additionally, the amount of payment for services provided may be affected by one or more of the following factors including, but not limited, to:

- Member's eligibility at the time of service
- Whether services provided are covered by the member's plan
- Whether services provided are medically necessary, as required by the member's plan
- Whether services provided require prior approval by the member's plan
- Amount of the provider's billed charges
- Member copayments, deductibles, coinsurance, and other member cost-share amounts
- Coordination of benefits with third-party payers as applicable
- Adjustments of payments based on claims processing procedures described in Section 2 – Claims Procedures
- Adjustments of payments based on provider payment integrity policies.

Peak Health applies site-of-service payment differentials, based on the place of service, to the reimbursement of physician or other healthcare professional services. Additionally, Peak Health does not reimburse a physician or other healthcare professional for the technical component of a service provided to a member registered as an inpatient or outpatient at a hospital or other facility.

Nothing contained in the participating provider agreement, or this manual is intended by Peak Health to be a financial incentive or payment that directly or indirectly acts as an inducement for providers to limit medically necessary services.

Note: Additional information may justify additional payment for some claims submitted by physicians and other healthcare professionals. For example, a provider's clinical notes may establish that a procedure initially determined as incidental to another procedure involved distinct and significant provider efforts during the provider's encounter with the patient.

Overpayments

Claims are reviewed for accuracy and recoupment/refund requests will be made if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong provider/member
- Coordination of Benefits
- Allowance overpayments
- Billed in error
- Duplicate
- Non-covered services
- Claim editing
- Terminated member
- Total charge overpaid

Third Party Liability / Auto Accident

When a member needs services outside the scope of normal circumstance, resulting of an auto accident or an injury at their place of employment, Peak health would not necessarily be primary payer for medical services. If automobile insurance or workman's compensation claims are on file for the incident(s), they would be the primary payer of record.

Coordination of Benefits

If Peak is not the primary payer of record, include Explanation of Benefit ("EOB") from the primary insurance carrier with coordination of benefits ("COB") Claims submitted for secondary payment. You may also submit the claims with a payment amount indicated from the primary payer, when doing so through EDI.

Denials and Appeals

Requests for Review of Denied Claims

Providers may request a review of claim payment denials by the plan(s). To obtain a review, providers must contact Peak Health Provider Service at the number listed on the back of the patient's Peak Health identification card or via a written request to the Peak Health claims address. For additional information, see Section 6 – Provider Claims Dispute Process, Member Appeals & Grievances Process for Peak Health's claims payment policy on claim disputes.

Request for Claims Dispute

If a provider disagrees with how Peak Health has adjudicated a claim, the provider should follow the procedures set forth in Section 6 - Provider Claims Dispute Process of this manual or any applicable state laws.

Balance Billing

Providers must accept payment in full from Peak Health for covered services provided to health plan members in accordance with the reimbursement terms outlined in the agreement. Members are responsible for applicable copayment, deductible, and coinsurance amounts. For covered services, providers may not balance bill members for an amount other than their applicable copayment, deductible, and/or coinsurance responsibilities. A reduction in payment because of claims processing procedures is not an indication that the service provided is a non-covered service.

Services That Are Not Medically Necessary: When Peak Health determines that rendered services covered under the terms of the applicable member plan were not medically necessary, the provider shall not bill, charge, seek payment or have any recourse against the member for such services. Except as described and outlined in Section 4.4 of the Participating Provider Agreement. Overpayments Contacts, General Inquiries, and Escalation Process: For more information on how to resolve recoupment.

Contacts for Other Issues

Contacts, General Inquiries, and Escalation Process: For more information on how to resolve recoupment concerns, such as overpayments, payment integrity reviews, disputes, and medical record requests, please contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm EST. You can leave a phone mail message after hours, on weekends, or holidays. Your call will be returned within the next business day.

Section 3 – Medical Management

Access to Medical Management Services

The mission of Peak Health Medical Management is to provide a holistic care experience for the member, their caregivers, and their providers. Medical management at Peak Health is broken down into the core service areas listed below:

- Care Management
  - Behavioral Health Management
  - Care Coordination and Discharge Planning
  - Care Management for Chronic Complex Condition
  - Preventive Health Strategies
- Pharmacy
- Utilization Management

Electronic Availability:

- The PeakProvider Secure Portal (WVU MyChart for providers with access to Epic through WVU Health System) enables providers secure access to view patient lists and to request/to review previously submitted authorizations via the "authorization search" option. The providers can also review claims and Remittance Advice statements.
- The In-Basket feature allows providers to communicate directly with the Peak Health team to address any patient-related questions.
- The CRM (Customer Relationship Management) button allows providers to submit appeals and customer service-related questions.
- Providers are able to view their patients' health record information via the Chart Review tab.

Telephone Availability: Monday through Friday 8:00am to 5:00pm ET. Confidential voicemail is available 24/7 which is checked daily and responded to on the next business day EST.

Provider Service 1-833-9-MYPEAK (1-833-969-7325)

Member Service 1-833-5-MYPEAK (1-833-569-7325)

Care Management and Quality

Care Management Programs: Peak Health is proud to offer a robust care management program. The program is comprised of four different tracks: routine care management; behavioral healthcare management; complex care management; and discharge / transition of care planning. Our Care Managers use health risk assessments paired with caregiver and provider referrals to ensure that each member maximizes their health potential.

Provider Referrals for Care Management: Providers may enter a referral for care management services electronically via the PeakProvider Secure Portal, by fax, or by mail. Providers may also contact Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Coordination and Transition of Care: Peak Health strives to provide excellent coordination and transitions of care. We commit to ensuring that our member experience and provider experience data are incorporated into our yearly work plan for care management. We encourage and welcome ongoing feedback from our members, their caregivers, and our providers.

Member Experience: Peak Health subscribes to a member-centric healthcare approach. After a six- month period of receiving benefits from or administered by Peak Health, the member receives a member experience survey. Our Coordinator, Quality, Grievances and Member Experience analyzes the data from the survey to develop process improvement opportunities to improve our member's experience.

Quality Metric Monitoring Programs and Performance Improvement: To provide high-quality care for our members, Peak Health maintains an ongoing performance improvement plan around the metrics that matter. A short list of the key metrics includes cost and utilization data; readmissions; preventive care; member and provider experience data; and program specific goals.

Pharmacy Management

Overview of the Pharmacy Plan: Peak Health provides the medical pharmacy benefit for each of our members. To provide expertise and timely management of pharmacologic utilization review, Peak Health is partnered with the Rational Drug Therapy Program (RDTP). RDTP is a part of the West Virginia University School of Pharmacy and utilizes the same medical necessity standards as the utilization management team at Peak Health. Our pharmacist at Peak Health acts as our key pharmacy-strategist to maintain policies and procedures and to develop future opportunities for innovation and ongoing advancement. A strict cadence is maintained for review of pharmacologics that require prior authorization. The requirements for medical necessity are approved by the Pharmacy and Therapeutics Committee as well as our Clinical Quality Governance Committee.

Utilization Management

How do we determine coverage: Members of the utilization management team evaluate medical necessity utilizing evidence-based guidelines and internal medical policies. In addition to medical necessity, the health plan evaluates the level of service and quantity-based benefits. A registered nurse will review requests to deem appropriateness to meet medical policy; however, only an appropriately licensed provider or pharmacist can deem a treatment or service to be not medically necessary.

Prior Authorization: Peak Health maintains a list of procedures and treatments that require prior authorization. This list is maintained on peakhealth.org. Providers, patients, and facilities will receive proper notification each time that this list is updated.

The prior authorization process includes the following components:

- Confirmation of member's eligibility
- Determination of medical necessity
- A decision is provided to the member and/or the provider prior to the service, treatment, or supply being granted
- Identification of members who have complex care needs and will require discharge planning and/or enrollment into disease specific care management programs

Emergencies: No prior authorization is required for urgent or emergent care. The prudent layperson must determine that the care falls within the Emergency Medical Treatment and Labor Act (EMTALA). The member must receive a proper and timely evaluation for treatment to prevent adverse outcomes.

Non-Covered Services: This is defined as any healthcare service for which a member is not entitled to receive coverage under the Terms and Conditions of a benefit plan. To verify coverage and eligibility, visit the PeakProvider Secure Portal or contact Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Medical policy bulletin updates: Peak Health is committed to issuing quarterly medical policy bulletins. This

document includes any items that have been removed or added to the prior authorization list. Peak Health ensures this document is distributed to allow for timely compliance with the standards.

Peak Health Medical Policies: Peak Health utilizes InterQual medical necessity criteria to guide utilization management evidence-based care philosophy. In cases where InterQual does not provide medical necessity criteria for procedural codes, Peak Health provides a policy. A list of procedural codes that require authorization, as well as the Peak Health written policies, can be found on peakhealth.org.

How to Submit a request for Coverage: Providers may submit coverage requests for treatments or services requiring authorization directly in Epic; providers outside of the WVU Hospital system and/or do not utilize Epic can submit requests for coverage via the PeakProvider Secure Portal. Providers can verify if a drug or service requires pre-certification at any time by contacting Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays. Additionally, requests can be accepted via fax at 304-974-3191.

Requests for medical treatments or services requiring authorization for clinical appropriateness will be reviewed as timely as possible and in compliance with all federal regulatory standards.

Notification of Decisions: Providers with access to Epic and the PeakProvider Secure Portal will receive notifications of decisions and requests for additional information electronically unless otherwise requested. If a provider does not have access to Epic or the PeakProvider Secure Portal, notifications of decisions will be made verbally, by fax, or by mail, depending on the information available and urgency of the situation. It is the responsibility of the provider to regularly check the referral and authorization work queue or other applicable communication method for notifications.

Diagnosis Related Group (DRG) Audits: To provide cost-effective and high-quality care, Peak Health is committed to performing Diagnosis Related Group (DRG) audits each quarter. The goal of the DRG audit is to ensure the proper procedure code has been utilized in the billing process. The hospital will be notified of the initiation of the audit, how the audit will be summarized, as well as the process to accept or appeal the revised procedural code.

Additional audits may be triggered by subsequent findings in the medical management, claims operations, or provider relations data analysis findings.

Section 4 – Office Procedures

This section provides policies and procedures that pertain to the daily operations of a provider's office.

Office Appointment and Wait Times

Providers should implement procedures and make reasonable efforts to comply with:

- External quality management regulators and programs
- The National Committee for Quality Assurance (NCQA)
- West Virginia Departments of Insurance Standards for Access to Care and Services

Appointment Accessibility Standards

- **Routine Care:** Within 21 calendar days (exceptions permitted at specific times when PCP capacity is temporarily limited)
- **Urgent Care:** Within 48 hours (2 calendar days)
- **Emergent Care:** Immediately (same day) or send to ER or call 911
- **Physical Exams:** Scheduled within 180 calendar days

Specialty Care: Specialty care providers should provide appointment access within 30 calendar days for new or established patients. Appointment access should be granted sooner for cases where it is medically appropriate or indicated. In-office waiting for appointments must not exceed one hour from the scheduled appointment time.

Prenatal Care Accessibility: Appointment Accessibility Standards For OB/GYN – An initial prenatal care visit must be scheduled within 14 calendar days of the date when the woman is found to be pregnant. First and second trimester visits must be scheduled within seven days of the request.
Third-trimester visits must be scheduled within three calendar days of the request. For high-risk pregnancies, appointments must be scheduled within three calendar days of identification as high- risk.

Behavioral Health Appointment Accessibility Standards

- Initial Visit for Routine Care ≤ 10 Business days
- Follow-up Routine Care of an initial visit for a specific condition
- ≤ 30 working days (Prescribers)
- ≤ 20 working days (Non-prescribers)

- **Follow-up after Inpatient Stay:** ≤ 7 days after discharge
- **Urgent Care:** Experiencing worsening of symptoms or new symptoms, that if not treated, could result in a more intense level of treatment, ≤ 48 hours
- **Non-Life-Threatening Emergency Care:** Extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, compromised ability to function, or is otherwise agitated and unable to be calmed, ≤ 6 hours
- **Emergency Services:** Immediately

After Hours Accessibility:

- Primary Care: After Hours/Weekends/Holiday Care Accessibility – Primary care provider or a designated covering practitioner should be available to Peak Health members within one hour of their leaving a message or contacting the answering service.

Address Change and Other Provider or Practice Information

For Peak Health to maintain accurate participating provider directories and for reimbursement purposes, providers are contractually required to electronically report any change of address or other practice information via the PeakProvider Secure Portal. Notices of any changes must adhere to time frames outlined in the agreement.

If a provider's agreement with Peak Health is through a Management Services Organization (MSO), Independent Practice Association (IPA), or provider medical group, these changes can be communicated to Peak Health through the entity rather than by the individual provider.

Changes or circumstances that require notice to Peak Health include, but are not limited to, the following:

- Provider demographic information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Office hours
- Phone number
- Practice name
- Adding a provider – provider joining practice/group**
- Provider deletions – provider no longer participating with the practice/group
- Provider or practice ownership structure without prior written consent of Peak Health
- Patient restrictions (age, gender, etc.)
- Accepting new patients
- Medicare numbers
- Hospital privileges
- Suspension, withdrawal, expiration, revocation of any license, certificate, or credential authorizing the practice of medicine or the delivery of hospital or other health care services;
- Suspension or revocation of DEA certification or other right to prescribe controlled substances;
- An indictment, arrest, or conviction of a felony or any criminal charge related to or in any way impairing the provider's practice of medicine;
- Loss or material limitation of provider's insurance as required by agreement;
- Debarment or suspension from any government sponsored program, including Medicare or Medicaid;
- The listing of the provider in the Healthcare Integrity and Protection Data Bank (HIPDB);
- Bankruptcy or receivership of Provider.

*Changes in practice name, legal entity or tax ID numbers might require an amendment, assignment, or new agreement, depending on the reason for the change. Questions can be directed to Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Physicians and other healthcare professionals can view their practice or facility information on Peak Health's online provider directory at peakhealth.org under "Find a Provider".

**If adding a provider, the new provider must first be credentialed before rendering treatment to any plan member.

Peak Health requires changes such as those outlined above to be submitted at least thirty (30) days prior to the effective date of the change to facilitate accurate directory information and claims payment.

Section 5 – Medical Records

Maintaining Medical Records

Medical Records: Providers are required to maintain current, detailed, comprehensive, and accurate medical records for each member to whom they provide services. The medical record is critical to ensuring the quality, coordination, and continuity of care for members. Each record must support the service billed and the level of care provided on each service date.

Medical records must be maintained in accordance with the following requirements:

- Each chart is labeled to allow for easy and timely retrieval by the provider or provider's staff to meet the patient's clinical needs;
- Records are systematically and timely prepared, filed, and stored; and
- Safeguards are in place to protect the confidentiality of patient records and information.

Peak Health provider representatives must be permitted access to the provider's office records and operations. This access allows Peak Health to monitor compliance with regulatory requirements. Each provider office will maintain complete and accurate medical records for all Peak Health covered patients receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation, and reimbursement rules and regulations to which Peak Health is subject
- Accepted medical practices and standards
- Peak Health's policies and procedures

The Health Insurance Portability and Accountability (HIPAA) Privacy Rule allows Peak Health to use and disclose members' protected health information (PHI) for treatment, payment, and healthcare operations. The provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, appeals and grievances processing, claims disputes, quality compliance audits, and other initiatives Peak Health might be required to conduct. To comply with accreditation and regulatory requirements, Peak Health may periodically perform a documentation audit of some provider medical records. The provider must meet 85% of the requirements for medical record keeping with a goal of 90%, or applicable state and federal requirements, if more stringent.

The participating provider must respond to the Peak Health member Appeals & Grievances unit expeditiously with submission of required medical records to comply with time frames established by CMS and/or the state department of insurance for processing appeals and grievances. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record and the submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to the local Peak Health market office unless the provider can ensure confidentiality of those medical records.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of Protected Health Information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. Providers are obligated to protect the personal health information of their Peak Health members from unauthorized or inappropriate use.

The agreement states whether the original or a copy of the medical record must be sent. If a provider terminates, the provider is responsible for transferring the patients' medical records.

Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to Peak Health covered patients nor to Peak Health, unless state regulations or the agreement stipulates otherwise.

Submitting Medical Records

Medical records are requested by Peak Health when there is not sufficient information to determine the medical necessity and appropriateness of the services being provided. Regulatory standards require health plans to make medical necessity decisions within strict timeframes. In some cases, the regulatory standard does not provide additional time for obtaining medical records. For this reason, it is important for providers to provide all relevant medical records within the time frame stipulated in the request. Lack of response or a late response to the request for medical records may result in a denial ofpayment.

Information on medical record requests is located in the Participating Provider Agreement, Section 3.9.

Providers can submit medical records to Peak Health in the following ways:

- The preferred method of intake is via the PeakProvider Secure Portal or via EpicCare Link for Epic users.
- For providers/affiliates unable to utilize the preferred method, medical records can be submitted via secure fax at 304-974-3470.
- For additional information, contact Provider Service 1-833-9MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Section 6 – Provider Claims Dispute Process, Member Appeals & Grievances Process

Provider Claims Dispute Process

If a provider disagrees with Peak Health's payment denial or nonpayment of a claim, they can request a dispute/reopening of the issue by calling or writing to Peak Health using the contact information on the back of the patient's Peak Health ID card. If this information is unavailable, please follow these instructions:

- The preferred method of intake is via the PeakProvider Secure Portal or via EpicCare Link for Epic users.
- For providers/affiliates unable to utilize the preferred method, medical records can be submitted via secure fax at 304-974-3470.
  For additional information, contact Provider Service 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

When submitting a request for dispute/reopening in writing, providers should include all of the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service
- Relationship of the member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation request
- Relevant supporting documentation (medical records, copy of invoice, etc.).

Claims disputes must be communicated to Peak Health within one hundred and eighty (180) calendar days from the date the claim was paid or denied—unless state or federal law or the agreement require another time period—or the claim will not be reopened.

See Section 2 – Claims Procedures for Peak Health claim payment policies and further information about claims disputes.

If the provider is unsatisfied with the outcome of the review, he/she can submit a request for a second dispute/reopening. Peak Health Provider Service reviews escalated issues when providers are unable to obtain resolution to disputes/re-openings via normal submission methods. Providers will need to include the same information that was submitted with the initial dispute along with any reference number provided during previous contact with Peak Health. Within 72 hours, the provider will receive an email with a reference number that they can use when contacting Provider Service at 1-833-9-MYPEAK (1-833-969- 7325) to inquire about the status of the review at any time.

> **Note:** The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in the participating provider agreement.

Internal Appeals Process

Members or their authorized representatives have the right to appeal any adverse benefit determination issued by our plan. An appeal may be filed within 180 calendar days of the adverse determination. The member, provider, or member's authorized representative may file an appeal. Members have the right to appoint anyone they choose, including an attorney, to submit an appeal on their behalf. The plan must be informed of any authorized representative in writing by completion of the authorized representative form found on the website at peakhealth.org . If the appeal is submitted by a representative prior to the plan's receipt of the written approval for the representative, the appeals process will not begin until this form is received.

Our appeal form can be found on the website at peakhealth.org. The appeal form or request should include the member's name, address, member ID, and all pertinent medical information, as well as any supporting documentation and written comments for review. An appeal may be submitted electronically via the PeakProvider Secure Portal, by fax, or by mail. Expedited appeals only may be filed by calling Peak Health Member Service at 1-833-5-MYPEAK (1-833-569-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Peak Health Appeals & Grievances
PO Box 4262 Morgantown, WV 26504-4262
Fax: 304.974.3191

TDD and TTY assistance as well as language services are available when calling Peak Health Member Service for assistance with the appeals process.

Our internal appeals process consists of 1 (one) level of review for self-funded group health plans. For adverse determinations involving medical necessity review, members have the right to a full and fair review by an appropriate practitioner with clinical expertise in the treatment of the disease or condition who was not involved in the initial decision and is not subordinate to the practitioner who made the initial decision. Correctness of the original decision will not be assumed, and all new information will be thoroughly reviewed and investigated prior to rendering a decision. Any required additional information will be requested from the member and/or provider. As not to delay the review process, if additional information is not submitted, the appeal will be reviewed based on the information currently on file.

For standard pre-service appeal requests, the plan will issue a decision within thirty (30) calendar days. For post-service appeal requests, the plan will issue a decision within sixty (60) calendar days. For expedited pre-service and concurrent care requests, the plan will issue a decision within 72 hours. A request for an expedited review will be considered for any medical care or treatment where reviewing within the standard time frame could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or where reviewing within the standard time frame would subject the member to adverse health consequences without the care or treatment requested. If an extension is required due to special circumstances, the plan will notify the member in writing of the extension. An extension will not be made without the member's permission and unless it is deemed to be in the best interest of the member.

At any time during the appeal process, a member, provider, or their authorized representative may contact Member or Provider Service to inquire about the filing or status of an appeal, to request a copy of their appeal file (including all relevant medical records and information obtained while investigating the appeal), or to request a copy of the criterion, rule, or guidance against which the appeal was reviewed.

Provider Service 1-833-9-MYPEAK (1-833-969-7325)
Member Service 1-833-5-MYPEAK (1-833-569-7325)

Member and Provider Service are available Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Peer-to-Peer Process

Within 5 business days of an adverse determination involving medical necessity, the provider may request a Peer-to-Peer discussion with a Peak Health provider or another appropriate practitioner by calling Provider Services 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays, or electronically via the PeakProvider Secure Portal, by fax, or by mail. Please provide any identifying member or claim information as well as the name of the treating provider requesting the peer-to-peer discussion and a contact number where the provider can be reached.

External Appeals Process

If an adverse benefit determination is issued through our internal appeals process or Peak Health fails to provide notice of a decision within the above-specified time frames, the member has the right to request an external appeal review through an Independent Review Organization (IRO) free of charge. Additionally, if Peak Health fails to strictly adhere to these appeal procedures, the member shall be permitted to request an external review.

The request for an external appeal must be filed within 4 months of the adverse benefit determination or final adverse benefit determination. Standard requests may be filed electronically via the PeakProvider Secure Portal, by fax, or by mail. Expedited requests only may be filed by calling Peak Health Member Service at 1-833-5-MYPEAK (1-833-569-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays. Please specify an external appeal review is being requested.

The appeals department will review the request and verify eligibility for external appeal review within 5 business days. The member will be notified of eligibility within one business day after the completion of the preliminary review by the appeals department and either (i) the request will be assigned at random to one of three contracted Independent Review Organizations (IRO) within ten (10) business days of original receipt or (ii) the member will be notified of the ineligibility for external review, along with the contact information for the Employee Benefits Security Administration (EBSA). The member will be notified once the request is submitted to the IRO with the name and contact information of the review organization as well as a list of all documents submitted on their behalf. The member has the right to submit any additional information deemed necessary directly to the IRO. The IRO will issue a decision to both the member and the plan within forty-five (45) business days from their receipt of the appeal for standard requests.

Peak Health will automatically refer all requests for expedited external review of adverse determinations to the randomly assigned Independent Review Organization (IRO) within 24 hours of the determination to uphold the initial denial. Along with the request, Peak will send a copy of the completed case file with an explanation of the adverse determination to the IRO. The member and plan will be notified of a decision by the IRO within 72 hours.

If an adverse benefit determination is issued through our appeals process, members also have the right to seek legal counsel. For questions regarding appeal rights, you may contact the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272) or the U.S. Department of Labor at 1-866-487-2365 for more information.

U.S. Department of Labor
https://www.dol.gov/

Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa

Complaints and Grievance Process

A complaint is any expression of dissatisfaction regarding the health plan or network of providers made orally or in writing. Examples of a complaint include concerns about wait times, demeanor of health care personnel, the adequacy of facilities, or respect paid to the member.

A grievance is a formal complaint or dispute other than one involving a request for coverage that expresses dissatisfaction with the manner in which Peak Health or a delegated entity provides services. Examples of a grievance include dissatisfaction with a refusal to expedite a request for coverage, concerns regarding timeliness of a request, concerns with the quality of care received, or concerns regarding access to care.

Dissatisfaction with an adverse benefit determination that was considered by the member or provider to be necessary will be classified as an appeal rather than a grievance.

If you are not satisfied with services provided to you by Peak Health, it will be our pleasure to work with you and do our best to resolve any issues. We encourage you to first call and discuss the reason for your dissatisfaction with a Member or Provider Service Representative.

A complaint or grievance may be reported by a member or their authorized representative by calling Member Service at 1-833-5-MYPEAK (1-833-569-7325) or Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to5:00pm ET, excluding holidays. A complaint or grievance may also be submitted in writing electronically via MyChart or by fax or mail to the address listed below. Peak Health must be informed of any authorized representative in writing by completion of the authorized representative form found on the web site at peakhealth.org prior to initiation of the grievance.

Peak Health Appeals & Grievances
PO Box 4262 Morgantown, WV 26504-4262
Fax: 304-974-3191

Peak Health will complete an investigation of formal grievances as quickly as the circumstance requires and send a resolution notice within thirty (30) calendar days from receipt of the request. If we need more time to investigate the situation, we will notify the member about the extension prior to the end of the initial 30-day period. For urgent grievance requests, we will send a resolution notice within 72 hours.

If you are still dissatisfied after a resolution decision has been received or have questions about your rights, you may contact the Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272) or the U.S. Department of Labor at 1-866-487-2365 for assistance.

U.S. Department of Labor
https://www.dol.gov/

Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa

Section 7 – Covered Services

A covered service must be medically necessary and appropriate as defined by the member's contract to be paid by the plan. To verify if a service is covered or excluded, please contact Peak Health Member Service at the number listed on the back of the patient's identification card. All covered services may be subject to applicable copayments, deductibles, and coinsurance.

Peak Health uses current, nationally approved criteria for medical necessity reviews and has developed rigorous medical/pharmacy coverage policies. Peak Health is not a provider of medical services and does not control the clinical judgment or treatment recommendations made by medical professionals.

Section 8 – Compliance/Ethics

Liability Insurance

Upon request, all providers must provide Peak Health with evidence of insurance coverage in accordance with their credentialing and contractual requirements.

Compliance

Providers who contract with Peak Health are responsible for complying with all applicable laws, regulations, policies, and procedures. In addition, providers must comply with the terms and conditions of their provider agreement(s) and meet acceptable standards for quality of clinical care, resource utilization, and administrative compliance to ensure that members receive high quality, medically appropriate, and cost-effective care. Providers who are not compliant will be subject to the corrective action policy providing for corrective action, sanctioning, suspension, and termination of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, resource utilization, and/or administrative compliance.

Section 9 – Plan Overview

Peak Health is a licensed Third-Party Administrator (TPA) with a full suite of tailored service offerings to meet the specific needs of self-funded clients including:

- Platform integration between Peak and health system to create efficiency and reduce redundancy
- Complete plan administration encompassing claim processing, member service, and enrollment
- Comprehensive medical management and utilization review
- Flexibility in plan design
- Best-in-class local network with robust national network access in all 50 states through Aetna's First Health Network
- Data sharing and detailed reporting
- Full digital experience

Section 10 – Credentialing

Credentialing is the process of obtaining and reviewing documentation to determine provider participation status in a health plan. The documentation may include, but is not limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence. The credentialing and recredentialing processes are performed by Peak Health employees who work cooperatively with providers to ensure members have access to only those practitioners who meet Peak Health's high standards of professional qualifications. When selecting and credentialing providers, Peak Health does not discriminate in terms of participation or reimbursement against any healthcare professional who is acting within the scope of their license or certification. Generally, the terms credentialing and recredentialing include the review of the information and documentation collected, as well as verification that the information is accurate and complete.

In order to participate in Peak Health's networks, a provider must:

- Complete the appropriate participation agreement(s), which include the terms of payment, and complete fully any required application or information forms;
- Abide by the terms and conditions of such agreement(s), including any amendments;
- Satisfy and remain in compliance with applicable Peak Health credentialing and recredentialing standards;
- Cooperate and comply with Peak Health's health services management programs, including but not limited to: prior authorization, care and case management, disease management, clinical quality improvement, and other programs and initiatives that may be adopted;
- Provide timely written responses to complaints or clinical quality issues upon request from Peak Health;
- Follow Peak Health's appeals processes and other dispute resolution procedures; and
- Adhere to Peak Health's billing, claims submission, and other administrative guidelines and requirements, including this Peak Health Provider Manual.

Peak Health completes the recredentialing process every thirty-six (36) months following completion of the initial credentialing process and has established policies for the protection of our members.

Providers have the right to review information submitted in support of their credentialing application, be notified of information that varies substantially from primary sources, and to correct erroneous information. Primary sources that may be contacted as part of the credentialing process include, but are not limited to, the following:

- State Licensing Bureau
- Drug Enforcement Agency
- Educational program(s) the provider has completed
- American Board of Medical Specialties, or American Osteopathic Association, if applicable
- National Practitioner Data Bank
- Office of the Inspector General participation/sanction date
- Federation of Chiropractic Licensing Board, if applicable
- Federation of Podiatric Medical Board, if applicable

Council for Affordable Quality Healthcare: Peak Health is a member of the Council for Affordable Quality Healthcare (CAQH). Peak Health is proud to be utilizing their next generation system CAQH ProView. CAQH is an online single-entry national database that eliminates the need for providers to complete and submit multiple credentialing applications. Physicians and other healthcare providers who are members of CAQH can submit an initial credentialing application to Peak Health and provide the required information at recredentialing rather than completing credentialing applications.

- If you are an initial applicant with Peak Health and are NOT currently participating in CAQH ProView:
  - Please visit https://proview.caqh.org/pr to obtain a CAQH ID and complete the application. The online solutions will guide you through the process, which will take several hours to complete the first time. The application does not need to be completed all at one time. Helpful resources are available through links on the login page to help you initially navigate the system. Be sure to select Peak Health as a plan authorized to receive your information.
  - After you successfully submit your form, Peak Health will retain an electronic copy of your CAQH ProView profile.
- If you are an initial applicant with Peak Health already participating in CAQH Proview and have a CAQH ID:
  - Please access the initial credentialing request form and complete the form by providing your information in the required fields. Please include your CAQH ID when completing this section of the form. CAQH is used for credentialing purposes only and not to update your Peak Health provider data.
  - Please visit https://proview.caqh.org/pr to review, update, and re-attest to your application. Be sure to select Peak Health as a plan authorized to receive your information.
  - After you submit your form successfully, Peak Health will retain an electronic copy of your CAQH ProView profile.

If a practitioner's name is different on any document than what appears on their current medical license, the practitioner should complete the Other Names section of their CAQH profile or complete a Name Verification Form.

Section 11 – Rights and Responsibilities

To comply with the requirements of accrediting and regulatory agencies, Peak Health has adopted certain responsibilities for participating providers (commercial, Medicare and Medicaid) that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and the agreement and providers must fully comply with all requirements regardless of their inclusion on this list.

Physician/providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Agree to comply with Peak Health's quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Peak Health.
- Be credentialed by Peak Health and meet all credentialing and recredentialing criteria as required.
- Not be on the CMS/OIG/SAM preclusion lists (Federal health care programs).
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable, and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan-member rounds and have no record of hospital privileges having been reduced, denied, or limited, or if so, provide an explanation that is acceptable to the plan.
- Inform Peak Health in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.
- Inform Peak Health immediately of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect his/her participation status with Peak Health.
- Not discriminate in the treatment of members, or in the quality of services delivered, on the basis of place of residence, their source of payment, age, race, color, ethnicity, national origin, religion, sex, sexual preference, health status or disability, claims experience, medical history, evidence of insurability, or genetic information.
- Not discriminate in any manner between Peak Health members and non-Peak Health members.
- Inform members regarding follow-up care or provide training in self-care.
- Assure the availability of physician services to members 24 hours a day, seven days a week (required for HMO PCPs and all MA providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Peak Health physician (required for HMO PCPs and all MA providers).
- Refer Peak Health members with problems outside of the physician's normal scope of practice for consultation and/or care to appropriate specialists contracted with Peak Health on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except in an emergency.
- Admit members only to participating network hospitals, SNFs and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Peak Health member, subscriber, or enrollee other than for copayments,

deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan, or fees for noncovered services furnished on a fee-for-service basis. Noncovered services are services not covered by Medicare, or services excluded in the member's plan.

- Provide services in a culturally competent manner (i.e., removing all language barriers; arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Providers must ensure that services, both clinical and non-clinical, can meet the cultural and linguistic needs of all members, including those with LEP, disabilities, reading skills, diverse cultural and ethnic backgrounds, sexual orientation, and the homeless; and are responsive to member needs and preferences. According to the United States Department of Justice's Civil Rights Division, a provider may not charge a patient for the additional cost of providing communication costs and services. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health at the following webpages:
    - http://minorityhealth.hhs.gov
    - https://thinkculturalhealth.hhs.gov/
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Peak Health policies.
- Treat all member records and information confidentially and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Upon request of Peak Health, provide an electronic, automated means, at no cost, for Peak Health and all Peak Health-affiliated vendors acting on behalf of Peak Health to access member clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to, case management, utilization management, claims review and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Peak Health providers upon request and at no charge to Peak Health, the member, or the requesting party, unless otherwise agreed upon.
- Provide copies of, access to, and the opportunity for Peak Health or its designee to examine the provider's office books, records and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
    - Influence, ownership, or control and:
    - Either a financial relationship or a relationship for rendering services to the primary care office.

The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance and peer review obligations, as well as any other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within 14 days of receipt of notification will be considered a breach of contract. For records related to Peak Health MA enrollees, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.

- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/sponsoring, whether through a protocol, collaborative, or some other type of agreement, Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), nurse practitioners (NPs) and all other healthcare professionals required to be supervised or sponsored, whether through a protocol, collaborative or some other type of agreement under applicable federal and state law in order to treat members.

- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a HEDIS service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form and submitted according to the time frame listed in the agreement.
- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Submit complete member referral information when applicable and in a timely manner to Peak Health via electronic means or telephone.
- Notify Peak Health of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Peak Health of any material change in provider's performance of delegated functions, if applicable.
- Notify Peak Health of his/her termination as per directive in Participating Provider Agreement Section 2.0 prior to the effective date of termination.
- Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial members, Medicare enrollees in an MA plan and Medicaid members.
- Respond expeditiously to Peak Health's requests for medical records or any other documents to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Peak Health plan(s) with which the provider is contracted.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with, to hinder communications between providers and members regarding a member's medical condition or available treatment options, or to dictate medical judgment.
- For providers who have downstream agreement(s) with physicians or other providers who provide services to Peak Health members, agree to provide a copy of said agreement(s) to Peak Health upon request (financial information is not requested).
- Abide by all state and federal laws regarding confidentiality, privacy, and disclosure of medical records or other health and enrollment information.
- Submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations, and policies.
- Understand and agree that provider performance data can be used by Peak Health.

Members' Rights and Responsibilities

Peak Health adheres to certain rules of accrediting and regulatory agencies concerning member rights. Peak Health members have certain rights and responsibilities when being treated by Peak Health contracted providers. The rights and responsibilities below reminds members and providers of those rights and the importance of maintaining healthy relationships.

Peak Health members have the right to:

- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A right to access their protected health information (PHI) that is contained in a designated record set, among other rights set forth in the HIPAA Privacy Rule. Each provider must have a mechanism in place

to provide this access.
- A right to expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities, or source payment.
- A right to expect Peak Health to adhere to all privacy and confidentiality policies and procedures.
- A right to receive services that are provided in a culturally competent manner.
- A right to receive treatment for any emergency medical condition.
- A right to select an in-network provider and not be balance billed for medically necessary covered services.
- A right to receive an Explanation of Benefits (EOB) and discuss that EOB with the plan.
- A right to file a claim or have a claim filed by a provider on their behalf.

Peak Health members have the responsibility to:

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- A responsibility to read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.
- A responsibility to obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
- A responsibility to be considerate and cooperative in dealing with the plan providers and respect the rights of fellow members.
- A responsibility to schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment. Providers may collect a reasonable fee from Peak Health members as permitted by law for missed appointments or for cancelling less than 24 hours before a scheduled appointment.
- A responsibility to express opinions, concerns, or complaints in a constructive manner.
- A responsibility to inform Peak Health of any change in their contact information, such as address or phone number, even if these changes are only temporary.
- A responsibility to pay all premiums and applicable copayments, coinsurance, and deductible amounts by the due date.
- A responsibility to follow healthcare facility rules and regulations affecting patient care and conduct.
- A responsibility to always have their Peak Health identification card available and use it while enrolled in the plan.
- A responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

Note: In some states, providers are required by law to post members' rights and responsibilities. To be in compliance with CMS' member's rights and responsibilities, Peak Health has a process in place for current and prospective beneficiaries to exercise choice in obtaining Medicare services.

Advance Directives: The Patient Self-Determination Act of 1990 and state law provide every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially.

These rights may be communicated by the member through an advance directive. Two kinds of advance directives are generally recognized by law: the living will and the durable power of attorney for healthcare.

The member's primary care office is not required to have living will or durable power of attorney blank forms available. However, the primary care office must have procedures in place to help assure that the existence of completed advance directive forms is conspicuously noted in the member's medical record.

Professional Conduct during Physical Examination of Plan Members: The member or provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the member, or the physician's/provider's assistant. Prior to an examination of a minor, the physician should obtain a parent or guardian's consent in the manner specified by the applicable law, regulation, or policy.

> **Note:** Some states have regulations that may conflict with these guidelines. In those instances, state regulations, if more stringent, take precedence over the guidelines stated above. It is the provider's responsibility to comply with any law, regulation, or policy dictating the presence of a chaperone.

Section 12 – Fraud, Waste, Abuse and Material Misrepresentation

Fraud is defined by state and federal laws and typically occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the purpose of receiving payments that an individual or entity is not eligible to receive. An example of fraud is billing for services not rendered.

Waste is defined as the overutilization of professional medical services or the misuse of resources by a healthcare provider. An example would include a provider who believes that every patient should receive an X-ray at every appointment.

Abuse is defined as incidents or practices of providers, physicians, or suppliers of services and equipment that are inconsistent with accepted sound medical, business, or fiscal practices. An example would be billing separate services that should be bundled under one service code.

When a provider submits claims to Peak Health for reimbursement, the provider is contractually obligated to ensure that the information in the claim accurately reflects the services performed as documented in the provider's records. Claims that do not accurately reflect the services performed are misrepresentations; when a misrepresentation results in an overpayment to the provider, it is a **material misrepresentation**.

Because the provider is contractually obligated to submit claims that accurately reflect the services performed, Peak Health may retroactively adjust payments to reflect the services actually performed following a review of the provider's records or receipt of other information that indicates a claim materially misrepresents the services performed. Peak Health may retroactively adjust payments in these circumstances and seek recoupment even where there is no evidence that the provider or entity intentionally submitted claims containing misrepresentations.

Section 13 – Delegation

What is Delegation?

Delegation is the formal process by which one enterprise, such as Peak Health, grants to another legal entity (the "delegate") the authority to perform certain functions on its behalf, such as:

- Credentialing of physicians, facilities, and other healthcare providers
- Provision of clinical health services, such as utilization management, disease management and complex case management
- Claims adjudication and payment

At Peak Health, we delegate only provider credentialing. A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. With partial delegation, only some of the activities associated with a particular function will be delegated. For example, partial delegation of utilization management might mean that referral management is delegated, while Peak Health retains the utilization management of inpatient services for members. The decision of which functions may be considered for delegation is determined by the type of contract a delegate has with Peak Health, as well as the ability of the delegate to perform the function pursuant to Peak Health's policies and procedures. The decision also is determined by accreditation organization standards, state/federal regulatory requirements, and whether the delegate accepts the required oversight of the function by Peak Health.

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner.

Contact your local Peak Health Network Services Consultant or call Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

Section 14 – Provider Directory

The Peak Health Provider Directory is a fast and easy way for members to locate providers they need in locations convenient for them. It is a valuable tool that offers current and potential members important details about your practice, including office location, hours of operation, parking availability and nearby public transit information. The Centers for Medicare & Medicaid Services (CMS) requires Peak Health to have the most current information on our providers and also requires ongoing review of all physician information listed in the Provider Directory. The National Committee for Quality Assurance (NCQA) also requires the Provider Directory to include, and Peak Health to confirm to, the same physician information as for CMS, as well as the physician's hospital affiliation. Hospital affiliation means the hospital(s) where physicians have admitting or attending privileges. Providers are required to review and update their information as soon as a change occurs. Providers who do not verify or update their data in a timely manner will be removed from the Peak Health Provider Directory. If you determine that your information is inaccurate in the online directory, you can conveniently contact Peak Health Provider Service at 1-833-9-MYPEAK (1-833-969-7325) Monday through Friday 8:00am to 5:00pm ET, excluding holidays.

The Peak Health Provider Directory can be found on at peakhealth.org

PeakHealth.org