PeakHealth

2024

Medicare Advantage 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. Additional information is furnished via CMS.Gov. See also: Medicare Managed Care Manual (cms.gov)

About Peak Health

Peak Health is headquartered in Morgantown, West Virginia. Peak's insurance services company is a joint venture among West Virginia United Health System, Marshall Health, Mountain Health Network, and Valley Health, and it provides those services to both Peak Health Insurance Corporation. This allows us to have a completely collaborative approach to insurance that will connect the bridge between the provider and the payer.

Our Vision is to be an inclusive, provider-led health plan that helps residents of West Virginia and beyond live healthier and fuller lives. Peak Health is taking bold steps towards improving health outcomes in West Virginia, western Virginia, and other surrounding areas. This is home to our employers and their families, so we are dedicated to offering a new approach to health care that is designed for our communities and delivered by local providers.

With the success of Peak, we can improve access and bring down health care costs and administration fees for patients and employers. Our Mission is to make health care more accessible, understandable, and collaborative. 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, or email Peak Health at PeakProvider@PeakHealth.org. Messages received on holidays and outside of our business hours will be returned within one business day. Participating Provider information is also available by using the "Find a Provider" function on the Peak Health Website at Find a Provider - Peak Health.

Section 2 – Claims Procedures

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. Providers should verify eligibility, determine if a referral, prior authorization, or notification is required and copayment responsibility before a service is rendered. One of the primary reasons a claim is rejected is incomplete or inaccurate eligibility information.

As of 2023, Peak Health offers Medicare beneficiaries with Medicare Advantage PPO option which replaces the traditional Medicare coverage with managed care options. Peak Health Medicare Advantage beneficiaries receive all the benefits offered by traditional Medicare as well as additional benefits.

Member eligibility can be verified through one of the methods listed below.

Online:

- Visit Peak Health Provider Login to access the Peak Provider 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. Monday through Friday, 8:00am to 5:00pm ET, excluding holidays. Messages received on holidays and outside of our business hours will be returned within one business day.
- Provide the subscriber's identification number and other authentication information.

Electronically:

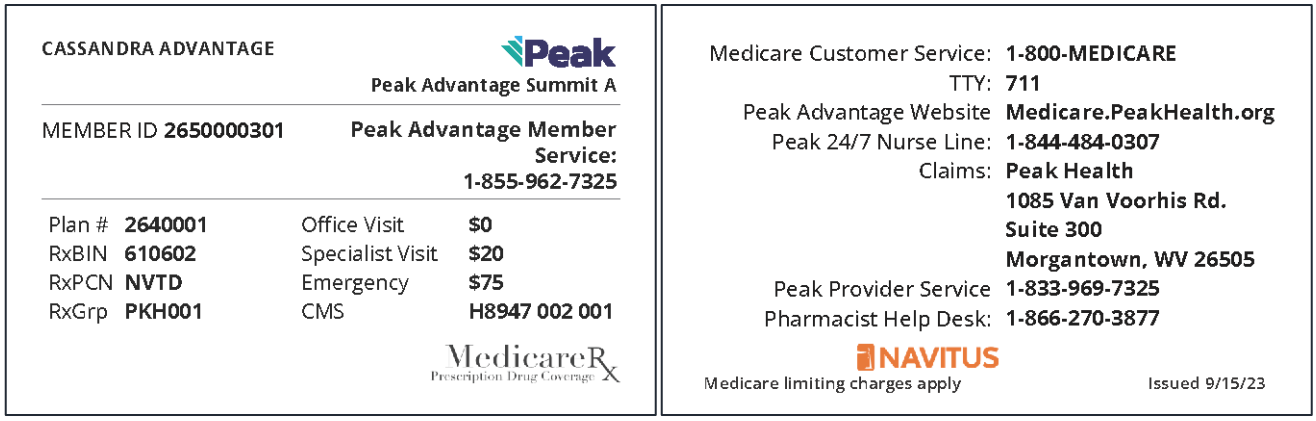
- Eligibility can be checked via a standard 270/271 EDI transaction.

Member Identification Card

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.

In addition to a physical copy that a member receives within 10 days of enrollment, Medicare Advantage Member identification cards can be accessed electronically on MyChart and contain information regarding a member's name, group number, deductibles, copayments, and Out of Pocket amounts. * Please refer to the physical copy of the Medicare Advantage Member identification card if a member does not have MyChart. * 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 11 characters. 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 Peak Provider 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. Please see the supporting link for guidance: MLN006379 – Medicare Overpayments (cms.gov)

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 with an 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

Peak Health requires all contracted providers that have the ability to submit claims electronically do so through their clearinghouse Electronic Data Exchange (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.

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
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

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. For MA claim processing requirements, Section 1833 of the Social Security Act prohibits payments to a care provider if there is not sufficient information to determine the "amounts due to such provider." Health care providers in our MA network must follow CMS guidance regarding billing, coding, claims submission and reimbursement. Per CMS requirements, you are required to use the 837 version 5010 formats. We reject incomplete submissions.

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
- The Medicare Claims Processing Guide (outlining guidance for MA)
- 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
- National Correct Coding Initiative (NCCI)
- Other applicable guidance from CMS, including the Official ICD-10-CM Guidelines for Coding and Reporting
- 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

ABN (Advanced Beneficiary Notice)

Don't use an ABN for Medicare Advantage (Part C) items and services or the Medicare Prescription Drug Benefit (Part D).

No Surprises Act

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What are surprise medical bills?

Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What are the new protections if I have health insurance?

If you get health coverage through your employer, a Health Insurance Marketplace®,[1]or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining theapplicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and thatpatient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

What if I don't have health insurance or choose to pay for care on my own without using my health insurance (also known as "self-paying")?

If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

What if I'm charged more than my good faith estimate?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

What if my state has a surprise billing law?

The No Surprises Act supplements state surprise billing laws: it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law providesat least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations,the state law generally will apply.For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the federal process.

As another example, if your state has an All-payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

Where can I learn more?

Still have questions? Visit CMS.gov/no surprises, or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059.

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.

MA UB-04/CMS-1450 Reminders:

Omission items listed below that may cause pended or not processed claims:

- Date and hour of admission.
- Date and hour of discharge.
- Member status-at-discharge
- Type of bill code (3 digits).
- Type of admission (e.g., emergency, urgent, elective, newborn).
- Current 4-digit revenue code(s).
- Attending physician ID number.
- For inpatient and outpatient services/procedures, the specific CPT or HCPCS codes, line-item date of service and appropriate revenue codes (e.g., laboratory, radiology, diagnostic or therapeutic).
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449).
- Any special billing instructions that are in your Agreement.
- On an inpatient hospital bill type of 11x, use the actual time the member was admitted to inpatient status.
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount ($10 or $100) on all other surgical revenue code lines to assure appropriate adjudication.
- The condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission nondiagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission.

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.

Medicare Fee Schedule Administration and Coding Requirements

For a complete listing of indicators, refer to the Medicare Claims Processing Manual, Chapter 23. Review the Addendum in Chapter 23, Section 50.6 for the latest information or refer to the Appendix in the back of this

booklet. Because Medicare only updates Chapter 23 every year, it's important to also review MLN Matters® articles and other information from CMS.

MA reference materials:
Medicare Claims Processing Manual (cms.gov)

Lookup Tool:
MLN901344 How to Use the PFS Look-Up Tool (cms.gov)
Search the Physician Fee Schedule | CMS

Examples of 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.

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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

Reference materials:

Ambulance Signature Requirements
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.

Ambulance Miles

For claims reporting ambulance miles, the following example should be used to code the line item: Mileage Reporting: A total of 10 miles (1 trip) was reported for HCPCS code A0425: Ground mileage, per statute mile.

Number of services:	10
MTUS (miles):	10
MTUS indicator:	1

For more information on Ambulance claims refer to:

Medicare Claims Processing Manual (cms.gov)

Hospice

When an MA member elects hospice, bill claims for:

- Hospice-related services to CMS.
- Services covered under Medicare Part A and B (unrelated to the terminal illness) to the Medicare administrative contractor. We are not financially responsible for these claims. We may be financially responsible for additional or optional supplemental benefits under the MA member's benefit plan such as eyeglasses and hearing aids. Medicare does not cover additional and optional supplemental benefits.

Medicare Crossover is the process by which Medicare, as the primary payer, automatically forwards Medicare Part A (hospital) and Part B (medical) claims to a secondary payer. Medicare Crossover is a standard offering for most Medicare-eligible members covered under our commercial benefit plans. Enrollment is automatic for these members.

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 (90-17517-55157-2022-0404-13-04-05-184 (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.

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 the 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

Medicare Advantage (MA) plans that have delegated arrangements with medical groups/Independent Physician Associations (IPAs) - in these arrangements, the delegate's protocols must be followed. Submit prior authorizations as directed on the member's ID card.

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/

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanction or excluded list, the Medicare preclusion list and/or health care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)1 list. Payment of covered services is based on:

- The member's benefit plan.
- Your eligibility for payment.
- Claim processing requirements.

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; 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 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
- Pharmacy
- Utilization Management

Electronic Availability:

The Peak Provider 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 new or 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 and submit appeals.

The CRM (Customer Relationship Management) button allows providers to view the status of previously submitted questions and appeals via CRM.

Telephone Availability:

Provider Service 1-833-9-MYPEAK (1-833-969-7325) Hours: 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. Messages received on holidays and outside of our business hours will be returned within one business day.

Member Service 1-855-9MA-PEAK (1-855-962-7325) Hours from October 1 to March 31: 8:00 am to 8:00 pm, 7 days a week. Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Care Management and Quality

Care Management Programs: Peak Health is proud to offer a robust care management program. Our program focuses on a member centered approach that assists members in managing and achieving their optimal health by utilizing all resources at their disposal including their familial, community, and medical support system. Our Care Managers use clinical assessment and health plan data to address members physical health, behavioral health, social determinates of health, and gaps in care. We identify members for care management engagement through claims and health plan data, member self-referrals, clinical assessments, health risk assessments, member and provider referrals, and other available sources to ensure that each member of Peak Health has the care management support to maximize 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 to improve our care management programs. 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. Annually, Peak Health conducts a randomized member experience survey to assess the member's overall plan satisfaction with the services provided by our network, providers, and operations. This is an opportunity to understand our member's experience and to develop mitigation strategies to ensure Peak Health is the plan of choice in our market service area. 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 – Medicare Advantage

Overview of the Pharmacy Plan: Peak Health provides the Part B medical benefit for each of our members and Navitus Health Solutions (NHS) will provide the Part D pharmacy benefit, serving as our Pharmacy Benefit Manager (PBM). Our plan follows all rules and regulations set forth by CMS.

Pharmacy Network: A member may fill prescriptions from any in network Medicare Advantage (MA) pharmacy. For more detailed information about our pharmacy network, please refer to medicare.peakhealth.org to locate our pharmacy directory.

Part D (Prescription Drug Benefit) – Navitus Health Solutions

Part D Formulary: A formulary is a list of covered drugs selected by our plan in consultation with a team of healthcare providers. The formulary represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Peak Health in network pharmacy, and other plan rules are followed.

The formulary is available on our website: https://medicare.peakhealth.org/assets/downloads/peak-advantage-formulary-guide-2024.pdf

Formulary Management: Peak Health and Navitus Health Solutions jointly develop the formulary. All changes to the formulary will be approved by the Navitus Health Solutions Pharmacy and Therapeutics Committee.

Part D Formulary Tier Structure
Medications are categorized into 5 tiers:

- Tier 1: Preferred generic drugs
- Tier 2: Generic drugs
- Tier 3: Preferred brand-name drugs
- Tier 4: Non-preferred drugs
- Tier 5: Specialty drugs

Part D Drug Coverage – General Information:

- **Deductible:** A deductible is the amount a member must pay before insurance will cover any expenses. Members have a $0 deductible that applies to all tiers for this plan.
- **Initial Coverage Limit:** During this phase, the member is responsible for a specific copayment or coinsurance for prescription drugs.
- **Coverage Gap:** While in the coverage gap, members will pay 25% of the total cost of brand-name and generic drugs in 2024.
- **Catastrophic Coverage Level:** Cost-sharing for Part D drugs will be eliminated for members who reach the catastrophic coverage phase.

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

- **Prior Authorization:** Our plan requires prior authorization for certain drugs. This means that a drug must receive approval before coverage. Our plan follows all coverage determinations as established by CMS. Standard coverage determinations are completed within 72 hours of receipt of request or prescriber's supporting statement for exceptions. Expedited coverage determinations must be completed within 24 hours of receipt of request or prescribers supporting statement for exceptions.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that is covered. For example, a drug may be limited to a certain number of units per prescription.
- **Step Therapy:** In some cases, our plan requires the member to try certain drugs for a medical condition before another drug is approved for that condition. For example, if Drug A and Drug B both treat a medication condition, Drug B may not be covered until Drug A is tried first. If Drug A does not work, Drug B will be covered.
- **Medicare Part D vs. Part B:** Some drugs can fall under Part D or Part B. Coverage determinations to determine Part D or Part B billing are dependent on several factors such as diagnosis, route of administration, and method of administration.
- **Opioid Safety Edits:** These restrictions are put in place by CMS to prevent and address prescription opioid overuse.

Members and providers can request exceptions to these restrictions/limits or for a list of other similar drugs that treat a medical condition.

Exceptions: There are several exceptions that can be requested by the member or provider. Examples are listed below:

- **Non-Formulary Exception:** A drug can be considered for coverage even if not listed on the formulary.
- **Tier Exception:** A request can be made for an exception to the plan's prescription drug cost sharing structure under certain circumstances. Tier exception rules vary by available alternatives, but general criteria for copayment reduction include:
    - The requested drug is being used for an FDA-approved indication.
    - The diagnosis is supported by one of the compendia:
        - American Hospital Formulary Service (AHFS)
        - DRUGDEX, with a strength of recommendation of IIB or better
    - History of failure, contraindication, or intolerance to ALL applicable formulary alternatives in the lower qualifying tiers.
- **Quantity Limit Exception:** If a drug has a quantity limit, requests can be considered for larger quantities if medically necessary.

In general, our plan will only approve exception requests if the alternative formulary drugs, lower cost sharing drug, or additional utilization restrictions would not be as effective in treating the medical condition or would

cause the patient to have adverse effects.

Part B versus Part D Drug Decisions: Our plan reviews CMS guidance pertaining to drugs that may be covered under either Medicare Part B or Part D depending on the situation on at least a quarterly basis. This guidance includes Medicare Chapters and HPMS memos as well as available National Coverage Determination (NCD, Local Coverage Determination (LCD), and Local Coverage Article (LCA) documentation. Information obtained from this review is used to update internal references and resources to ensure appropriate BvD categorization and payment. Categories of drugs impacted by BvD decision-making include, but are not limited to:

- Drugs that are furnished "incident to" a physician's service
- Drugs requiring the use of durable medical equipment (DME) for administration (such as nebulizer and infusion pump)
- Drugs that are always considered to be renal dialysis services
- Immunosuppressant drugs used to prevent transplant rejection
- Immune globulin
- Oral anti-cancer drugs (self)
- Oral anti-emetic drugs
- Parenteral nutrition
- Vaccines (select)

Our plan identifies drugs within the applicable BvD categories and implements the appropriate point-of-sale (POS) edits and/or messaging to ensure pharmacies process the drug through the appropriate benefit.

Hospice Part D vs Part D Drug Decisions: For prescription drugs to be covered under Part D when the member has elected hospice, the drug must be considered treatment of a condition that is completely unrelated to the terminal illness or related conditions. Our plan uses available guidance to identify drugs (and related dosage forms) within the following categories for the implementation of point-of-sale edits and/or retrospective claims review processes:

- Analgesics
- Anti-emetics
- Laxatives
- Anti-anxiety drugs

Our plan will administer the beneficiary-level prior authorization on all drugs within these categories for potential Part D eligibility. Since determination is necessary to establish whether the drug may be covered under Part D at all, a Part D enrollee's transition benefit has no impact on applying these edits.

Transition Process: Our plan abides by CMS guidelines for this process. The adjudication system logic automatically identifies claims eligible for a temporary supply of non-formulary Part D drugs (including Part D drugs that are on the part D formulary, but require prior authorization, step therapy, or have an approved QL lower than the beneficiary's current dose under utilization management rules) and effectuates payment during the first 90 days of the members benefit period in order to accommodate the immediate needs of the member. For these claims, a transition notice will be sent to the member and prescriber. This allows sufficient time for the prescriber to make an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

In certain circumstances, Navitus Health Solutions will extend the transition period and provide the necessary drugs if the enrollee's exception request or appeal has not been processed by the end of the minimum transition period.

Vaccines: Part D covers most vaccines and the administration fees, but some are covered under the medical (Part B) benefit. Part D covers most preventative vaccines and Part B covers flu, pneumococcal, hepatitis B (for intermediate or high-risk individuals) and some other vaccines (e.g. rabies) for intermediate or high-risk individuals when directly related to treatment of an injury or direct exposure to a disease or condition.

Medication Therapy Management: Medication therapy management (MTM) is a service offered by Navitus Health Solutions at no additional cost to members. It is required by CMS. To qualify, members must meet the requirements for at least one of the following two groups:

- Must have at least three of the following conditions or diseases:
    - Diabetes
    - Dyslipidemia
    - Hypertension
    - Depression
    - Asthma

AND
Must take at least 8 covered Medicare Part D medications
AND
Are likely to have greater than $5,330 per year in covered Medicare Part D medication costs
OR
Must be an at-risk beneficiary as defined by the Opioid Overutilization Monitoring System (OMS) minimum criteria established by CMS.

Services Offered by MTM Program:

- **Targeted Medication Review:** A members prescription medications will be reviewed every 3 months and the physician will be contact if potential problems are detected.
- **Comprehensive Medication Review (CMR):** At least once a year, a free discussion and medication review is completed with a healthcare professional to ensure safe medication use. This is a confidential service offered on behalf of Navitus Health Solutions via telephone or in person at the provider's office, pharmacy, or long-term care facility.

To determine eligibility, members can call the Navitus Medication Therapy Management (MTM) program team at 1-888-913-7885, Monday through Thursday 8a.m. to 7p.m. Central Time and on Friday 8a.m. to 5p.m. Central Time. TTY users can reach the program team through the National Relay Service 711, during the same hours as shown above.

Retrospective Drug Utilization Review: Retrospective drug utilization review (RDUR) is a safety-focused program that is in place to ensure safe, effective, and appropriate prescription drug use for all members. Coordinated care is encouraged among the healthcare team, which results in quality care for members.

Services offered by RDUR Program:

- **Morphine Milligram Equivalent:** Identifies patients with an average 90 MME or greater per day by more than one prescriber and pharmacy within a specific time frame; also includes patients who are taking opioid potentiator medications.
- **Multi-Prescriber:** Identifies patients who have utilized multiple prescribers to obtain prescription medications within a specific timeframe.
- **Controlled Substance Monitoring:** Identifies patients with potential overuse of controlled medications (Schedules II through V) and who visit an unusually high number of prescribers, pharmacies, and prescriptions for controlled medications within a specific timeframe.

- **Duplicate Therapy:** Identifies patients using multiple drugs in the same therapeutic class consistently within a specific timeframe.
- **Triple Threat:** Identifies patients who have concurrent use of opioids, benzodiazepines/hypnotics, and skeletal muscle relaxants within a specific timeframe.
- **Multi-Prescription:** Identifies patients with a high number of medications who have demonstrated a consistent pattern of utilization within a specific timeframe.
- **Expanded Fraud, Waste, and Abuse:** Identifies patients whose recent claims include medications with potential for overuse or abuse.

Part B (Medical Drug Benefit) – Peak Health

Formulary Management: Peak Health's Pharmacy and Therapeutics Committee develops the Part B drug formulary in accordance with § 422.137.

Part B Covered Drugs: Drugs covered under Part B are typically administered and obtained at the healthcare provider's office. In some cases, they are dispensed by outpatient pharmacies (examples include certain injections, some oral cancer drugs, insulin when administered by a pump, immunosuppressants for Medicare-covered transplants, and diabetic test supplies).

Part B Prior Authorization: Peak Health maintains a list of drugs that require prior authorization. This list is maintained on https://medicare.peakhealth.org. Providers and members will receive proper notification each time this list is updated.

Pharmacy and Therapeutics Subcommittee: The Pharmacy and Therapeutics Subcommittee is an established subcommittee of the Peak Health Clinical Governance and Quality Committee and provides guidance and oversight on matters related to the selection, utilization, evaluation, and management of drugs within Peak Health. The subcommittee consists of a multidisciplinary group with expertise in clinical pharmacy, medicine, nursing, and other relevant areas.

Utilization Management

How do we determine coverage: Members of the Peak Health utilization management team evaluate medical necessity in accordance with guidance outlined by the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs) and applicable Local Coverage Determinations (LCDs). In the absence of an applicable NCD, LCD, or other CMS published guidance, Peak Health develops and maintains clinical policies by utilizing evidence-based medical standards and clinical guidelines published in credible peer-reviewed medical literature. 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 medicare.peakhealth.org Providers, members, 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

Peak Health requires authorization of inpatient stays, certain services, procedures, and/or Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) prior to performing the procedure or service. The authorization is typically obtained by the ordering provider. Some authorization requirements vary by member contract.

The preferred - and fastest - method to submit preauthorization requests and receive approvals is our online portal. The online portal is designed to facilitate the processing of authorization requests in a timely, efficient manner. Providers who do not have access can submit authorizations via fax.

Emergencies: No prior authorization is required for urgent or emergent care. The Emergency Medical Treatment and Labor Act (EMTALA) guarantees access to emergency medical services for an individual who presents to a hospital emergency department, regardless of an individual's ability to pay. The member must receive a proper and timely evaluation for treatment to prevent adverse outcomes. Peak Health is financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The plan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

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.

Provider newsletter updates: Peak Health is committed to issuing quarterly or more frequent medical policy updates via a provider newsletter. . 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. Interqual criteria for Medicare Advantage reviews follow applicable NCD, LCD, or other CMS published guidance in compliance with Medicare regulations. In cases where InterQual does not provide medical necessity criteria for procedural codes, Peak Health will provide its own internal policy. A link to the Interqual transparency tool which provides read-only access to all Interqual criteria as well as access to all Peak Health internal medical policies can also be found on our website at medicare.peakhealth.org via the Peak provider portal.

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.

Section 4 – Office Procedures

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

Available Providers and Services

To determine the type or specialty of provider available for your specific need or requirement, please visit the Peak MA Provider Directory at: medicare.peakhealth.org/directory/.

The "Find a Provider" option will assist you in identifying not only the provider specialties, but also the available providers in your geographic area.

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

Care Connection Virtual Urgent Care Visits

Peak Health will consider reimbursement for telehealth services performed in a West Virginia location while the member was at home or another originating site under certain commercial and MA benefit plans.

To be eligible for payment, you must meet the following telehealth service requirements:

- Comply with the American Medical Association (AMA) and Federation of State Medical Board guidelines, which require all telemedicine visits use live interactive audio and video as well as visual transmission of a physician-patient encounter.
- Use a secure technology platform that meets federal and state requirements for security and confidentiality of electronic member information.
- Comply with all applicable federal and state laws concerning the security and confidentiality of member information, including HIPAA and its governing regulations.
- Maintain member records related to telehealth services in a secure medium that meets federal and state requirements for encryption and security of electronic member information. Additionally, records should include the application/service used to conduct the telehealth visit.
- Offer telehealth services in a clean, private space and not in vehicles or public spaces.
- Code the telehealth services in accordance with applicable reimbursement policies.

Appointment Accessibility Standards

Peak Advantage has written standards for appointment wait times for primary care and behavioral health services which must meet or exceed the minimum standards as follows:

- Urgently needed services or emergency—immediately.
- Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 7 business days; and

- Routine and preventive care—within 30 business 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) o ≤ 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 by emailing the request to peakprovider@Peakhealth.org, or accessing the appropriate forms on the Peak Provider Webpage at: Peak Provider - Peak Health. 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 privacy and confidentiality of patient records and information in accordance with applicable law, regulation, and provider's contractual obligations, including but not limited to, the Participating Provider Agreement and Business Associate Agreement

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:
- 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) without authorization 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.

As required by the -HIPAA Privacy Rule, 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 of payment.

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

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 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.

Peer-to-Peer Process

A peer-to-peer consult may be obtained pre-decision during the corresponding review timeframe of the coverage request. Providers 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. If clinical information is received after a notification of a decision is complete or if a peer-to-peer request is made after notification of a decision is complete, the situation will be handled as an appeal or reconsideration.

Medicare Advantage Appeal Process For Medical Services And Part B Drugs

The levels of the Medicare Advantage appeals process are as follows:

Level 1 Appeal- Reconsideration from the plan

If an adverse determination is issued by Peak Advantage for a medical service/ item or a Part B drug, an appeal may be submitted within 60 days of the original denial. The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.

There are two different types of appeals:

Standard Appeal: A written decision will be provided within 30 days for a medical service/item and 7 days for a Part B drug. If the appeal is for a payment of a medical service/item or Part B drug that has already been received, a written decision will be provided within 60 days.

Expedited (Fast) Appeal: A decision will be provided within 72 hours after the appeal is received. An expedited (fast) appeal can be requested if the doctor/member believes that the member's health could be seriously harmed by waiting for a standard appeal. An expedited (fast) appeal cannot be requested if the member is asking for our plan to pay back for a medical item/service or Part B drug that has already been received.

Extensions:
For standard pre-service and fast appeals for items and services, our plan may extend the timeframe by up to 14 calendar days if the member requests the extension or the extension is in the member's best interest due to the need for additional medical evidence. Part B drug appeal timeframes cannot be extended.

How to ask for an appeal:
The member, member's representative, or doctor must ask for an appeal. The appeal request must include:
Member's name
Member address
Member phone number
Reasons for appealing
If an expedited (fast) vs standard appeal is requested (for an expedited (fast) appeal, must provide an explanation)
Any evidence that should be reviewed for the case such as medical records, doctor's letters (such as a supporting statement if an expedited (fast) appeal is requested), or any other information that explains why you need the medical service/item or Part B drug.

The appeal can be mailed, faxed, submitted electronically, or delivered. Members and providers can also call with the required information.

For a Standard Appeal:
Mailing Address:

Peak Health
Attn: Appeals and Grievances Department
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505
1.855.962.7325
TTY Users Call: 711

Fax: (304) 974-3191

Website:
medicare.peakhealth.org

In Person Delivery Address:
Peak Health Plan
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

For a Fast Appeal:
Phone: 1.855.962.7325
TTY Users Call: 711
Fax: (304) 974-3191

medicare.peakhealth.org

Peak Health Contact Information:
Phone number: 1-855-962-7325 (TTY: 711). Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week. Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Inpatient Discharge Appeals:
If a Medicare member disagrees with a plan's decision to discharge or discontinue services from inpatient hospital, skilled nursing, home health, or outpatient rehabilitation, they have the right to appeal. Requests must be made to the Quality Improvement Organization (QIO) in the state in which services were provided. The Quality Improvement Organization is an independent reviewer authorized by Medicare to review these decisions and the result is final.

Contact information for the Quality Improvement Organization along with instructions to appeal will be provided to the patient prior to discharge from the hospital via the standard CMS Important Message (IM) form (CMS-10065). This information can also be found at www.cms.gov/bfcc.

If the Medicare member asks for this review before leaving the hospital, The QIO will contact the hospital staff to get medical records for review. The QIO will notify the member of their decision as soon as possible. If a member asks for the review after midnight on the day of discharge or after leaving the hospital, this will be handled through the plan's expedited grievance and appeal process outlined in this section.

Level 2 Appeal -Independent Review Entity (IRE)

If an adverse determination is issued through our internal appeals process or if Peak Health fails to provide notice of a decision within the above-specified time frames, the plan will automatically send the request and a completed case file with an explanation of the adverse determination to be reviewed through an Independent Review Entity.

CMS contracts with MAXIMUS Federal Services to conduct these reviews. MAXIMUS will issue a decision within 72 hours for expedited appeal requests, 30 days for standard pre-service medical service/ item requests and 7 days for standard pre-service Part B drug requests. Post-service appeal requests will be decided within 60 days. MAXIMUS will contact the appellant directly with their decision.

Level 3 Appeal -Office of Medicare Hearings and Appeals (OMHA)

If the member is dissatisfied with the IRE's decision and the amount in controversy is $180 or more (2023 threshold), they have the right to file a request for an Administrative Law Judge (ALJ) hearing within 60 days from the date of receipt of the IRE decision letter or QIC dismissal notice for inpatient discharge appeals.

If requesting an escalation to OMHA, the member may file a request with the QIC for OMHA review after the appeal period expires. The receipt date is presumed to be 5 days after the notice date unless there's evidence it was not received within that time.

Level 4 Appeal- Medicare Appeals Council (MAC)

If the member disagrees with the ALJ or attorney adjudicator decision or dismissal, or they wish to escalate the appeal because the OMHA adjudication time frame passed, a review by the Medicare Appeals Council may be requested.

The Council is part of the HHS Departmental Appeals Board (DAB).
Council review requests must be filed within 60 days from the date of receipt of the OMHA decision or dismissal. The receipt date is presumed to be 5 days after the notice date unless there's evidence it was not received within that time.

Requests may be made in writing using the OMHA decision instructions or by completing a Request for Review of ALJ Medicare Decision/Dismissal (DAB-101).

Level 5 Appeal- Federal District Court

If the member disagrees with the Council decision, or wants to escalate the appeal because the Council decision time frame passed, a judicial review request may be filed.

The judicial review request must be filed within 60 days from the date the Council decision was received or after the Council decision time frame expires.

Medicare Advantage Appeal Process For Part D Prescription Drugs

If an adverse determination is issued for a Part D drug, an appeal may be submitted within 60 days of the original denial.

There are two different types of appeals:

- **Standard Appeal:** A written decision will be provided within 7 days from receipt of the appeal. If the appeal is for a payment of a drug that has already been received, a written decision will be provided

within 14 days.

- **Expedited (Fast) Appeal:** A decision will be provided within 72 hours after the appeal is received. An expedited (fast) appeal can be requested if the doctor/member believes that the member's health could be seriously harmed by waiting for a standard appeal. If the member asks for an expedited appeal without support from the doctor, we will decide if the situation requires an expedited appeal. The member will be notified if we do not allow for an expedited appeal and a decision will be provided within 7 days.

How to ask for an appeal:
The member, member's representative, or doctor must ask for an appeal. The appeal request must include:

- Member's name
- Member address
- Member phone number
- Reasons for appealing
- If an expedited (fast) vs standard appeal is requested, (for an expedited (fast) appeal, must provide an explanation)
- Any evidence that should be reviewed for the case such as medical records, doctor's letters (such as a supporting statement if an expedited (fast) appeal is requested, or any other information that explains why the members needs the drug.
- If requesting an exception to a coverage rule, the doctor must provide us with a supporting statement including information about why the coverage rule should not apply to the specific medical condition
- If the appeal relates to a decision by us to deny a drug that is not on our formulary, the doctor must indicate that all the drugs on any tier of our formulary would not be as effective to treat the condition as the requested off-formulary drug or would harm the member's health.

The appeal can be mailed, faxed, submitted electronically, or delivered. Members and providers can also call with the required information.

Navitus Health Solutions Contact Information:
Navitus Customer Care: 1-866-270-3877 or, for TTY users, 711, 24 hours a day, 7 days a week except for Thanksgiving and Christmas days.

For a Standard Appeal:
Mailing and In Person Delivery Address:

Navitus Health Solutions
PO Box 1039
Appleton, WI 54914-1039

Fax: (855)-668-8552

For an Expedited (Fast) Appeal:

Phone: 1-866-270-3877
TTY Users Call: 711

Fax: (855)-668-8552

If an appeal is denied, the case will automatically be sent to an independent reviewer. If the independent reviewer denies the request, the member will be sent a written decision and an explanation of additional appeal rights, if applicable.

Medicare Advantage Complaints And Grievance Process For Medical Services

A grievance is any complaint or dispute, other than one involving a request for coverage, that expresses dissatisfaction with the way 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 Advantage, 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 grievance may be reported by a member or their authorized representative by calling Peak Advantage Customer service at the contact number listed below. A 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 https://medicare.peakhealth.org prior to initiation of the grievance. Grievances must be filed no later than sixty (60) days after the event or incident precipitating the grievance.

Peak Health Contact Information:

Mailing Address:
Peak Health
Attn: Appeals and Grievances Department
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

Fax: 304-974-3191

Phone number: 1-855-962-7325 (TTY: 711). Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week. Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Additionally, you can submit a complaint about your Peak Advantage plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Peak Health will complete an investigation of all grievances as quickly as the circumstance requires and send a resolution notice within thirty (30) calendar days from receipt of the request. If the member requests an extension or if Peak Advantage justifies a need for additional information and documents how the delay is in the interest of the member, the 30-day timeframe may be extended by up to 14 days. Members will be notified about an extension prior to the end of the initial 30-day period. For expedited grievance requests which meet the requirements for an expedited or fast investigation, Peak Advantage will send a resolution notice within 24 hours.

Grievances filed regarding a decision by the plan not to grant a member's request to expedite an initial determination or appeal or regarding the plan's decision to extend a timeframe related to an organization determination or appeal, will automatically be treated as expedited grievances with a resolution being reached within 24 hours.

Peak Advantage will respond in writing to all grievances related to quality of care within 30 days or as expeditiously as the member's health requires. quality of care complaints, Medicare members have the right to file a complaint with the Beneficiary and Family Centered Care- Quality Improvement Organization (BFCC-QIO) in the state in which services were rendered. If a complaint is submitted to the QIO, Peak Advantage will coordinate with the QIO in resolving the complaint. For more information on contacting the BFCC-QIO, please see https://www.cms.gov/bfcc.

Medicare Advantage Complaints And Grievance Process For Part D Prescription Drugs

A grievance may be reported concerning Part D prescription drug services by a member or their authorized representative by calling Navitus Customer Care. Additionally, a grievance may be submitted in writing electronically, by fax, or by mail to the contacts listed below. Grievances must be filed no later than sixty (60) days after the event or incident precipitating the grievance.

Navitus Health Solutions Contact Information:
Navitus Customer Care: 1-866-270-3877or, for TTY users, 711, 24 hours a day, 7 days a week except for Thanksgiving and Christmas days.

Mailing and In Person Delivery Address:

Navitus Health Solutions
PO Box 1039
Appleton, WI 54914-1039

Fax: 1-844-268-9791

Additionally, you can submit a complaint about your Medicare Advantage plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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.

For additional information go to https://medicare.peakhealth.org/helpful-resources/

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.

CMS no longer requires FDRs (like providers) to complete these trainings: January 2019 Medicare Parts C and D General Compliance; January 2019 Combating Medicare Parts C and D Fraud, Waste, and Abuse. However, Peak Health does require that you use and complete your own version of general compliance and FWA training that covers those topics while being tailored to your organizational needs. Required education and training for your employees must be completed: within 90 days of initial hire or the effective date; when materials are updated; annually thereafter. If you use training logs or reports as evidence of completion, they must include: employee names; dates of completion; passing scores (if captured).

Peak Health's Compliance Program is administered by the Chief Compliance Officer, Andrew Heineman. The Compliance team works hard to ensure Peak Health's members and beneficiaries are treated in accordance with all regulatory rules and requirements. Here are key points of contact you should be aware of and utilize as a provider of health or administrative services to Peak Health members:

Compliance Concerns	Report any potential compliance concerns you have by:
	• Calling Peak's Compliance Hotline: 1-844-860-9049
	• Submitting an online form at: https://peakhealth.ethicspoint.com
	• Contacting Medicare directly at:
	  ○ 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048; or
	  ○ https://www.medicare.gov/my/medicare-complaint

Fraud, Waste, & Abuse (FWA)	Report any potential FWA concerns you have by:
	• Calling Peak's FWA Hotline: 844-859-2485
	• Submitting an online form at: https://peakhealthfwa.ethicspoint.com/
	• Contacting Medicare directly at:
	  ○ 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048; or
	  ○ https://www.medicare.gov/my/medicare-complaint

Peak Health will not retaliate against you for reporting alleged instances of FWA or compliance concerns. If you would like, you are always able to report instances of FWA and compliance concerns anonymously using the above methods.

If warranted, Peak Health, providers contracted with Peak, and Peak's FDRs must report potentially fraudulent conduct to government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS.

First-tier, Downstream, and Related Entities

CMS expects Peak Health to communicate annually about our Compliance and FWA programming to "first tier, downstream and related entities" (FDRs). Contracted physicians, health care professionals, facilities, and ancillary providers, as well as delegates, contractors and related parties are considered FDRs. Peak Health requires FDRs that perform administrative or health care services on behalf of the plan to ensure their employees meet CMS, Federal Contracting, and general compliance requirements. FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. Peak Health expects that FDRs and their employees are sufficiently trained to identify, prevent and report incidents of non-compliance and FWA.

Fraud, Waste, & Abuse and Material Misrepresentation

As a provider of health or administrative services to Peak Health members, you play a vital role in preventing, detecting, and reporting potential instances of fraud, waste, and abuse (FWA). Prevention of FWA happens when you conduct yourself in an ethical manner, ensure accurate and timely reporting, and know and follow Peak provider policies and procedures. As such, you have a duty to report, which means you must report any concerns and suspected or actual instances of FWA of which you may be aware. See the above table for information on how to report concerns of FWA. Peak Health will not retaliate against you for making a good faith effort in reporting instances of FWA. You also may report instances of FWA anonymously.

What is fraud, waste, and abuse? Their formal definitions are below, but generally, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit. There are many differences between fraud, waste, and abuse, but one of the primary differences are *intent* and *knowledge*. Fraud requires *intent* to obtain payment and the *knowledge* the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same *intent* and *knowledge*. There are also key regulations that provide the legal framework for awareness, detection, and enforcement of FWA. Those include: the Civil False Claims Act; Health Care Fraud Statute; Criminal Health Care Fraud; Anti-Kickback Statute; Stark Statute (Physician Self-Referral Law); Civil Monetary Penalties (CMP) Law; and, Health Insurance Portability and Accountability Act (HIPAA).

- **Fraud:** knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000.
- **Waste:** includes practices that, directly or indirectly, result in unnecessary costs to the Medicare

Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

- **Abuse:** includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Once FWA is detected, you have a responsibility to correct and report it promptly. Doing so protects Peak beneficiaries and members, saves the government money, and ensures compliance with CMS requirements. Any associated corrective actions will be coordinated through the Peak Compliance Department and could vary from repayments and updated policies to disciplinary action up to and including contract termination.

Knowing how to respond is important, and so too is knowing how to identify instances of FWA. As provider of health or administrative services to Peak Health members, providers should look to ensure they do not: encourage and support inappropriate risk adjustment submissions; lead the beneficiaries to believe the cost of benefits is one price, when the actual cost is higher; offer beneficiaries cash inducements to join the plan; nor, utilized unlicensed agents. Doing any of the previous examples would indicate FWA and should be reported immediately. Other indications of potential FWA could include, but are not limited to:

- possible forged prescription, medical record, or laboratory testing;
- numerous identical prescriptions for a single beneficiary, possibly from different doctors;
- instances of identity theft;
- billing for services not provided or not medically necessary;
- prescriptions missing a provider's active and valid National Provider Identifier;
- diagnosis for a member that is not supported in the medical record.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a government directed investigation and civil or administrative litigation. Details to include when reporting suspected FWA, include:

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

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

Privacy and Confidentiality

Peak Health, pursuant to 45 C.F.R. §§ 164.103 and 164.105 and other guidance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), operates as a "hybrid entity" and designates certain entities as covered health care components. HIPAA and related regulations protect individually identifiable information regarding an individual's health and the provision of health care to that individual. Such information is referred to as "Protected Health Information" or "PHI." HIPAA applies to entities that perform health-care related functions, including entities that provide health care services ("Covered Entities"). HIPAA regulates the use and disclosure of PHI by Covered Entities and imposes administrative, technical, and physical standards, including implementation specifications, to ensure that PHI is kept secure. All providers and Peak FDRs must comply with HIPAA and related regulations that protect PHI.

Exclusion Screenings

Federal law prohibits Medicare, Medicaid and other federal health care programs from paying for items or services provided by a person or entity excluded from these federal programs. So, before hiring or contracting and monthly thereafter, each FDR must check exclusion lists. This will help confirm that your employees and downstream entities aren't excluded from participating in federally funded health care programs. To comply with CMS requirements your organization needs to check both the OIG and the GSA exclusion lists. This will ensure these individuals and entities are not excluded.

Your organization must maintain evidence that you've screened against both lists. This includes source documentation such as screenshots, input lists and/or documentation with date stamps. You may keep logs that track the dates for all screened employees and FDR. This will help track exclusion screenings. Also, make sure to keep source documentation. If any of your employees or downstream entities are on an exclusion list, you must immediately: remove them from any direct or indirect work on our Medicare plans; notify Peak Health.

Section 9 – Plan Overview

Peak Health Insurance Corporation is a West Virginia-licensed insurer providing Medicare Advantage plans in the state; for more information visit medicare.peakhealth.org/.

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.

Provider information is updated as Peak Health is made aware of changes, and updates are completed within 30 days of receipt, or within 30 days of the effective date of change. The Peak Health database is refreshed every 24 hours; some information may not be current if changes are not reported. You can submit a change request using our online form at Peak Provider - Peak Health

On Site Reviews

Per Peak Health's On-Site Review Policy: Peak Health or its designee will assess the quality safety and accessibility of office sites where care is delivered to members by performing on site reviews only in cases where a site is not accredited, or CMS approved. Peak Health staff will document the results of a structured review of the site and medical record keeping practices in order to verify conformance with standards upon initial credentialing, subsequent reappointments and as needed in connection with complaints. Peak Health Providers must agree to allow the Credentialing Entity to conduct an office site visit of said provider's practice. (CFR-Title 42: Part 455 and WV CSR 114-53-6).

Medicare Enrollment Provider Resources

Become a Medicare Provider or Supplier | CMS

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.

Peak Health Responsibilities

- Peak Health will provide enrollees notice of a termination of a contracted provider, irrespective of whether the termination was for cause or without cause, in accordance with § 422.2267(e)(12). Peak Health will make a good faith effort to provide enrollees notice of a for-cause termination of a contracted provider within the timeframes required by this paragraph
-
- In selecting practitioners, Peak Health will not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If Peak Health declines

to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision." Regulation does not preclude Peak Health from:

1. (1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).
2. (2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
3. (3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

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.

Medicare opt-out

We follow, and require our health care providers to follow, Medicare requirements for physicians and other practitioners who opt out of Medicare. If you opt out of Medicare, you may not accept federal reimbursement. Health care providers who opt out of Medicare (and those not participating in Medicare) are not allowed to bill Medicare or its MA benefit plans during their opt-out period for 2 years from the date of official opt-out. For our MA membership, we and our delegated entities do not contract with, or pay claims to, health care providers who have opted-out of Medicare. Exception: In an emergency or urgent care situation, if you have opted out of Medicare, you may treat an MA beneficiary and bill for the treatment. In this situation, you may not charge the member more than what a non-participating health care provider is allowed to charge. You must submit a claim to us on the member's behalf. We pay Medicare-covered items or services furnished in emergency or urgent situations.

PCP initiated Member dismissals

It is recognized by Peak Health that there are certain instances where a PCP may choose to terminate a patient relationship. While we will not interfere with the PCP's decision, we will:

- Remind the PCP of their obligation to terminate the relationship in accordance with applicable requirements.
- Help ensure the PCP provides us a reason for making the decision.
- Require documentation that they have communicated this decision to the member.

Each dismissal should be carefully considered based on the facts and circumstances specific to the member. In addition, PCPs who wish to terminate their relationship with a Medicare Advantage (MA) member and have a member reassigned must:

- Comply with all applicable legal and regulatory requirements.
- Send a certified letter to the member (evidence that the letter was mailed is acceptable even if a letter comes back as "undeliverable as addressed").
- Provide continuity of care as required by applicable laws and regulations.
- Provide us written notice.

Information Required from the PCP

For member reassignment, we require the following information from the PCP:

- The reason for reassignment or termination.
- Member's name, date of birth, address and member ID number.
- PCP's name, NPI and TINs.
- Copy of certified letter the PCP sent to the member notifying them of the termination.

We use good faith efforts to reassign the member to another PCP within 90 days of receipt of request. Changes will not be applied retroactively.

As a Medicare Advantage organization, Peak Health and its network providers agree to meet all laws and regulations applicable to recipients of federal funds.

If you participate in the network for our Medicare Advantage products, your compliance is required with the following additional requirements for services provided by you to our Medicare Advantage members:

• Discrimination against members in any way based on health status is prohibited.
• Allow members direct access to influenza vaccination and screening mammography services.
• Do not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.
• Female members must be provided with direct access to a women's health specialist for routine and preventive health care services.
• Be certain members have adequate access to covered health services.
• Be certain your hours of operation are convenient to members.
• PCPs are required to have backups for absences.
• Adherence to CMS marketing regulations and guidelines is necessary. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the health care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
• Provide services to members in a culturally competent manner considering adjustments for members who use English as a second language, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
• Cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care.
• Document in a prominent part of the member's medical record whether they have executed an advance directive.
• Provide covered health services in a manner consistent with professionally recognized standards of health care. • You must make sure any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
• Comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act, and the Anti-Kickback Statute; and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164.
• The payments you receive from Peak Health or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
• Cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
• Comply with our processes for notifying members if your participation agreement terminates.
• Submit all Risk Adjustment Data (see definition in glossary), and other MA program and commercial insurance related information we may request, within the time frames specified and in a form that meets MA program requirements as well as state and federal commercial insurance requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information and belief.

• Comply with our Medicare Advantage policy guidelines, coverage summaries, quality improvement programs, and medical management procedures.
• Cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
• Cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
• Comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA) in your Provider Agreement

Member communication (CMS approval required)

Member communications require CMS approval. This includes:

- Anything with the Medicare Advantage name or logo, including Medicare Advantage Dual Special Needs Plans.
- Correspondence that describes benefits.
- Marketing activities.

- Approval is not necessary for communications between health care providers and patients that discuss:
- Patient medical condition.
- Treatment options and/or plan.
- Information regarding managing patient medical care.

Once CMS approves, Peak Health sends the letter to the member. In addition to making sure the letter is approved by the governing regulatory body, Peak Health directs the letter to the correct audience. For example, Peak Health may need to distinguish a mailing to Medicare Advantage plan individual members versus Medicare group retiree members, as their benefits are distinctly different.

Requirements of Part C reporting

MA organizations are subject to additional reporting requirements. As a result, we may request data from you. Providers are required to comply with all requests for additional information made by Peak Health related to Part C reporting.

Some measures are reported annually, while others are reported quarterly or semi-annually. This includes, but is not limited to:

- Grievances.
- Organization determinations/reconsiderations including source data for all determinations and reopening
- Special needs plans care management.
- Rewards and incentive programs.
- Payments to health care providers.
- Telehealth benefits

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 Xray 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.

Responsibilities: You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.

- FIRST, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- SECOND, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware. You (and our members) may report it directly to CMS.
- THIRD, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA. FWA training must occur within 90 days of initial hire and at least annually thereafter. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website- Get training | CMS

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.

Available Providers and Services

To determine the type or specialty of provider available for your specific need or requirement, please visit the Peak Provider Directory at: medicare.peakhealth.org/directory/

The "Find a Provider" option will assist you in identifying not only the provider specialties, but also the available providers in your geographic area.

Section 15 – Skilled Nursing Facilities

The below table illustrates several fields required for Skilled Nursing Facility on the CMS -1450 claim form.

UB-04 Field	Report
FL 04 Type of Bill (TOB)	21X for SNF inpatient services. 18X for hospital swing bed services.
FL 06 Statement Covers Period (From/Through)	**From**date must be the admission date or, for a continuing stay bill, the day after the Through date on the prior bill. **Through**date is the last day of the billing period.
FL 31–FL 34 Occurrence Code/Date	50 with the Assessment Reference Date (ARD) for each assessment period on the claim with Revenue Code 0022 (not required for the defaultHealth Insurance Prospective Payment System [HIPPS] code).
FL 35 & FL 36 Occurrence Span Code (From/Through)	70 with the dates of the 3-consecutive-day qualifying stay.
FL 42 Revenue Code	0022 to show you're submitting the claim under the SNF PPS. You can use this revenue code as often as necessary to show different HIPPS rate codes and assessment periods.
FL 44 HCPCS/Rate/HIPPS Code	HIPPS rate code (SNF billing practices related to HIPPS codes remain the same under PDPM). Must be in the same order the patient got that level of care. Certain HIPPS rate codes need additional rehabilitation therapy ancillary revenue codes. If you don't include the corresponding codes, your MAC returns the claims for re-submission.
FL 46 Units of Service	Number of covered days for each HIPPS rate code.
FL 47 Total Charges	Zero for 0022 revenue code lines.
FL 67 Principal Diagnosis Code	ICD-10-CM code for the principal diagnosis.
FL 67A–FL 67Q Other Diagnoses	ICD-10-CM codes for up to 8 additional conditions.

Table above location:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/snf-billing-reference.html
More information on Skilled Nursing Facility Billing can be located via CMS at:
Skilled Nursing Facility Billing Reference - MLN006846 (cms.gov)

Section 16 – Medicare Preclusion List

Beginning April 1, 2019, CMS's new Preclusion List will go into effect subsequently barring many healthcare professionals from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. But what is the Preclusion List? Who is on it? Why was created?Don't worry, we're going to break down everything you need to know about this new CMS action and how it can affect your organization.

The Preclusion List is a list generated by CMS that contains the names of prescribers, individuals, and or entities that are unable to receive payment for Medicare Advantage (MA) items and service and or Part D drugs prescribed or provided to Medicare beneficiaries.

CMS has given two ways for which someone can end up on the Preclusion List. The first one way is if you:
"Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program."

However, even if you are not revoked from Medicare, you still may find yourself on the Preclusion List. CMS is also precluding anyone that has:
"... Engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but are not limited to, felony convictions AND Office of Inspector General (OIG) exclusions."
In April of 2018, within theFederal Register Rules and Regulations update, the Department of Health and Human Services releasedinformation on policy changes to Medicare programs. In which, they discussed the Preclusion List and their reasoning for establishing the new rule. It seems that CMS has given a few reasons for putting this new rule into effect:

- *"To focus on preventing payment for Part D drugs prescribed by demonstrably problematic prescribers."*
- *"Reduce the burden on Part D prescribers and Medicare Advantage providers without compromising our program integrity efforts."*And to
- *"To replace the Medicare Advantage (MA) and prescriber enrollment requirements."*

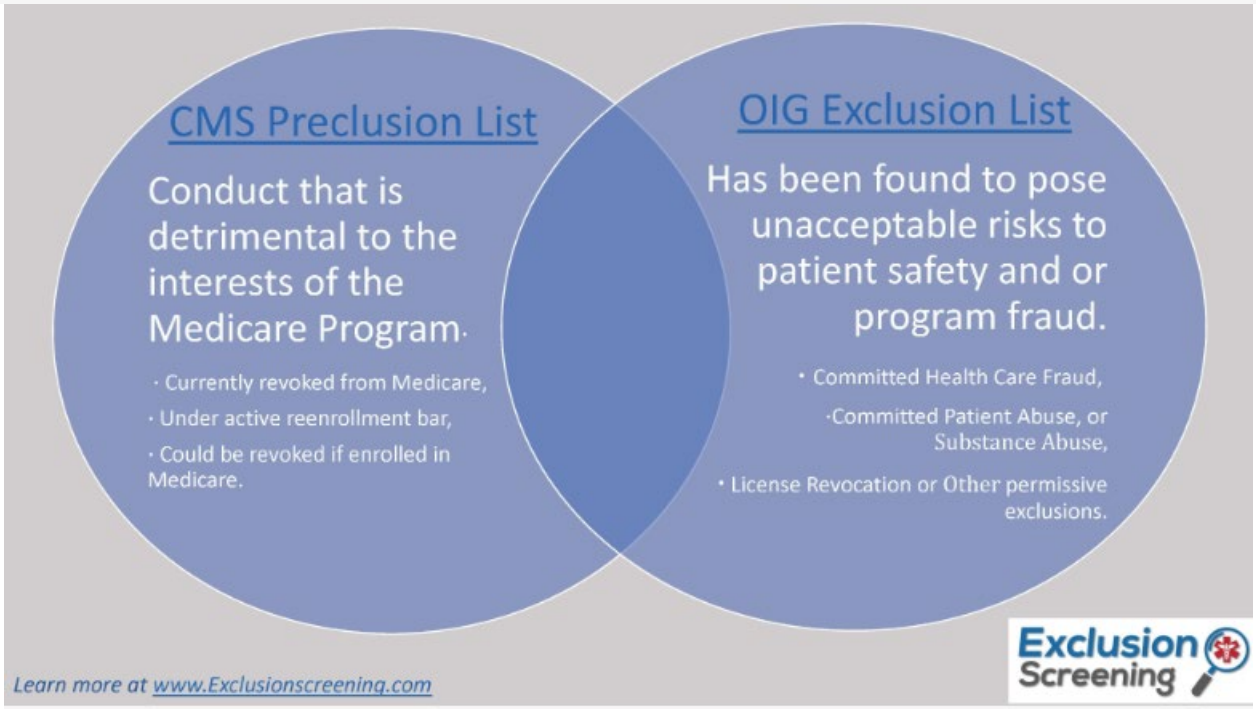
By doing this, CMS believes that it will save***$34.4 million*** dollars in 2019. These savings would be derived from the removal of the requirements for Part D prescribers and Medicare Advantage providers and suppliers to enroll in Medicare prior to providing health care services and items.

Unlike theOffice of Inspector General's (OIG) monthly exclusion list, the Preclusion list will not be shared publicly. Precluded providers however will receive notice in a variety of ways. First, CMS will issue an initial email notification to the precluded providers using their email addressed which they provided to either the Provider Enrollment, Chain and Ownership System (PECOS), the National Provider Plan and Enumeration System (NPPES), or from the Medicare enrollment system of record. The Medicare Administrative Contractor (MAC) will also follow up by sending a written notice through the mail to the precluded provider before they are added to the Preclusion List. Within this letter you will also be informed on why exactly you are precluded, the date that your preclusion will go into effect, and your applicable appeal rights.

Are Dentists at Risk of Being Precluded?
YES. If a dentist has been revoked from Medicare, is under an active re-enrollment bar, and CMS has found that the actions that led to their original revocation is a risk to the integrity of the Medicare program or has engaged in behavior for which CMS could have excluded them from participating in Medicare if they had enrolled.

The first list of providers that were to be precluded were published and were sent notice on **January 1, 2019.** However, beginning **April 1, 2019,** Part D sponsors will become required to reject any prescriptions for Medicare Part D drugs that are prescribed by an individual or entity that is on the Preclusion List. Medicare Advantage (MA) plans will also become required to deny payments for any healthcare service or item that was provided by and individual or entity that is on the Preclusion List.

The OIG Exclusion List is ***NOT*** the same as this new CMS List. That being said, there is some overlap. If you have been excluded, you can still find yourself on the Preclusion List if you fall into the either of the two criteria listed above under the ***"How Does Someone End up on The Preclusion List?"*** section. As you can see in the diagram below, there is some overlap, but not much.



Link to image and information above: What to Know About the New CMS Preclusion List – Exclusion Screening LLC (wpengine.com)

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