ApexHealth
Provider Manual

apexhealth

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Provider Manual

The ApexHealth Provider Manual is specifically designed for the ApexHealth provider network. This manual is intended to assist providers in understanding the specific policies, procedures, and protocols of ApexHealth, which is contracted with the Centers for Medicare and Medicaid Services (CMS) to deliver and manage health care for our members.

Updates and Revisions

While the Provider Manual and the Regulatory Requirements serve as dynamic tools that will evolve with ApexHealth, any minor updates and revisions to the policies, procedures, and protocols contained within will be communicated to providers via Provider Bulletins.

Updated information disseminated in Provider Bulletins will supersede the information found in the body of the Provider Manual.

Major revisions of information contained within the Provider Manual will result in the publication of a revised edition that will be distributed to all providers.

Medicare

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers 63 million Americans. Medicare is a health insurance program for individuals 65 years of age and older, some disabled individuals under 65 years of age, and individuals with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills, outpatient hospital care, and other medical services not covered by Part A.

Part A

Medicare Part A (hospital insurance) typically covers services like inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care.

Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or their spouse has worked at least ten (10) years in a Medicare-covered employment, is age 65, and is a citizen or permanent resident of the United States.

Certain younger disabled persons, kidney dialysis, and transplant patients qualify for premium free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and eighty (80) percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B

Medicare Part B (medical insurance) pays for many medical services and supplies, not covered under Part A, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received – at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage and the amount of their premium is set annually by CMS.

Medicare Part B coverage includes:

- Outpatient hospital services
- X-rays and laboratory tests
- Diagnostic services and tests
- Certain ambulance services
- Durable medical equipment (DME)
- Services of certain specially qualified practitioners who are not physicians
- Physical and occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and pap smears
- Home health care (if a beneficiary does not have Part A)

Part C

Medicare Part C (Medicare Advantage) was established with the Balanced Budget Act of 1997 (BBA). Prior to January 1, 1999, Medicare HMOs existed as Medicare Risk or Medicare Cost plans. The Balanced Budget Act of 1997 was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Special Needs Plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

Special Needs Plans (SNPs) offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum.

Medicare Star Ratings

The Centers for Medicare & Medicaid Services (CMS) measure quality of care provided from all Medicare Advantage and Prescription Drug Plans, including ApexHealth, through their Star Rating Program.

The Star Rating is based on a 1-5 scale, with a 5-Star rating being the highest quality. The intent of the Star Rating is to promote quality, ensure public accountability, and to give beneficiaries the tools needed for choosing a high-quality health plan that fits their needs during fall open enrollment.

The Star Rating is publicly available, influences member perception and is tied to reimbursement through rebates and bonus dollars. Those funds are utilized to enhance member benefits and reduce member out of pocket costs.

Star Rating Components

The 2023 Star Ratings are based on 40 unique measures across the following domains: Staying Healthy, Managing Chronic Conditions, Drug Safety, Member Experience, Member Complaints, and Customer Service.

Sources of performance data include:

- Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of healthcare performance measures in the United States. HEDIS Measurement Year (MY) 2023 includes 96 measures across the following domains: Effectiveness of Care, Access & Availability of Care, Experience of Care, and Utilization.
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey is administered annually to a large sample of MA & PDP beneficiaries using a protocol that includes two survey mailings and telephone follow-up. Questions ask about ease of getting care needed and seeing specialists, getting appointments and care quickly, doctors who communicate well, coordination of care services, ease of getting prescriptions filled, rating of health care quality, annual flu vaccine and pneumonia vaccine.
- Health Outcomes Survey (HOS) is a patient-reported outcomes survey. A baseline survey is administered to a new cohort, or group, each year. Two years later, these same respondents are surveyed again (i.e.

follow-up measurement). Questions ask about their opinion of their current health status, their current mental health status and their physical activities of daily living.

Star Rating Timeline

The health plan's Star Rating is based on services and experiences from two years prior. The timeline shows the development of the Plan Year 2025 Star Rating.

During 2023, our members will be receiving care, experiencing our health plan operations and interacting with you and your office staff. The data that comprises those activities is collected, audited and reported during 2024. In fall of 2024, our Plan Year 2025 Star Rating will be released in time for open enrollment specifically so that members can evaluate all of their options prior to choosing the best plan for them.

The Provider Impact

More than half of the Star Rating measures are influenced by our network of providers. Every provider has the opportunity to impact the success of a plan's Star Rating by influencing the patient's experience and by coordinating appropriate care. On average, providers have a higher impact on keeping the member satisfied than the Medicare Advantage plan.

Our partnership goals with our providers are to:

- Increase member engagement at provider offices through tailored member outreach
- Improve member outcomes by addressing open care gaps at every visit

How we can help/What we offer:

- Every ApexHealth member is assigned a Concierge Services Representative, who coordinates services directly with the member and your office.
- Diabetic Improvement Program for selected members

Quality Improvement

Quality Improvement Committee (QIC)

ApexHealth has a Quality Improvement Committee (QIC) that serves as a formal mechanism to consult with physicians who have agreed to provide services under the health plan offered by our organization, regarding our medical policy, quality improvement programs and medical management procedures and ensure that clinical practice guidelines are based on reasonable medical evidence or a consensus of health care practitioners in the particular field, consider the needs of our members, are adopted in consultation with contracted health care professionals and are reviewed and updated periodically.

Provider Participation

All Practitioners and providers are encouraged to participate in The Centers for Medicare & Medicaid Services (CMS) and Health and Human Services (HHS) quality improvement initiatives that comprise ApexHealth's quality improvement program.

Member Eligibility and Enrollment

Beneficiaries who wish to enroll in an ApexHealth Medicare Product must meet the eligibility criteria defined below:

Medicare Advantage (MA-PD)

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Permanently reside in the ApexHealth Service Area
- Complete an enrollment election form fully and accurately
- Be completely informed and agree to abide by the rules of ApexHealth

ApexHealth will accept all beneficiaries that meet the criteria in this section without any reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family status. Additionally, we will not limit, or condition coverage of plan benefits, based on any factor that is related to the member's health status, including but not limited to; medical condition, claims history, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Member Disenrollment

Voluntary Disenrollment (Disenrollment Requested by the Member)

A member who requests to disenroll from ApexHealth may only do so during a valid election period. If a member is requesting disenrollment from ApexHealth, they should be instructed to contact the health plan to be informed of their valid options to do so (as determined by CMS).

Involuntary Disenrollment (Disenrollment Requested by the Health Plan)

ApexHealth will request disenrollment of members from the health plan only as allowed by CMS regulations. We will request that a member be disenrolled under one of the following conditions:

- The member provided fraudulent information on the election form.
- The member has engaged in disruptive behavior.
    - Disruptive behavior is defined as behavior that substantially impairs the plan's ability to arrange for, or provide, services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following:

- The member abuses the enrollment card by allowing others to use it to obtain fraudulent services.
- The member leaves the service area and directly notifies us of the permanent change of residence.
- The member has informed the plan of a permanent move or has not permanently moved but has been out of the service area for 6 months or more, we will request that the member be disenrolled.
- The member loses entitlement to Medicare Part A or Part B benefits.
- The member is deceased.
- If ApexHealth loses or terminates their contract with CMS.
    - In the event of plan termination by CMS, we will send CMS approved notices to the member and a description of alternatives for obtaining benefits. The notice will be sent in accordance with CMS regulations, prior to the termination of the plan.

- ApexHealth discontinues offering service in specific service areas where the member resides.

In all circumstances, ApexHealth will provide a written notice to the member or member's estate with an explanation of the reason for the disenrollment. All notices will comply with the CMS Rules and Regulations.

Verifying Member Eligibility

Once enrolled, all ApexHealth members will receive an ApexHealth Member Identification (ID) card that will contain information about the plan they are enrolled with. Providers must verify a member's eligibility prior to rendering services.

To ensure that a member is eligible to receive services as an ApexHealth member, you should always request that the member presents his/her Member ID card at every visit. To verify eligibility, you can:

- Call Concierge Services
- Utilize the Online Provider Portal

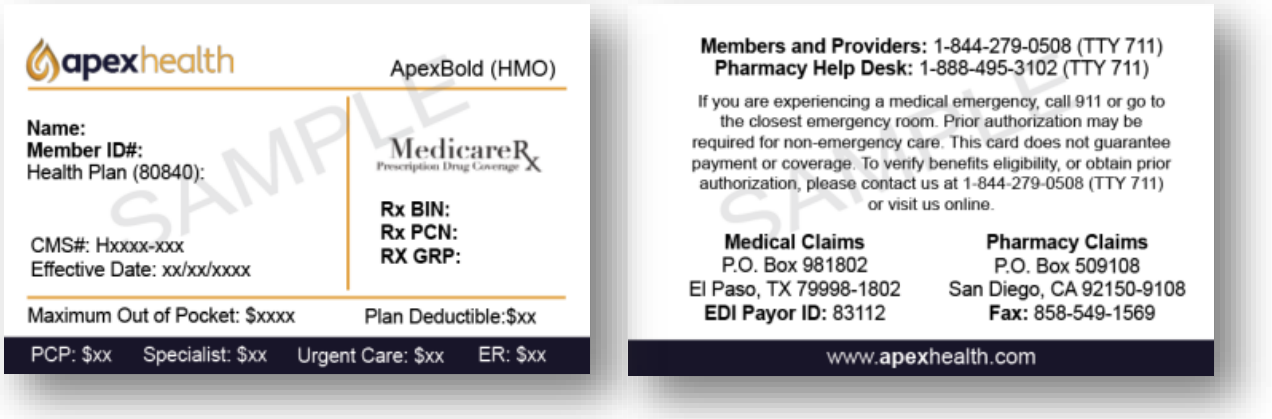
When inquiring about a member's eligibility, you must ensure that you have the following member information for validation:

- Full Name
- Date of Birth (DOB)
- Member ID Number

If a provider cannot verify all three (3) pieces of primary information (full name, DOB, Member ID), one (1) secondary piece of information with two (2) primary information identifiers can be used for verification. These secondary pieces include address and phone number. Providers must verify at least three pieces of information, with the member's full name being mandatory.

Please note, if you identify any discrepancies between what is displayed on a member's ID card, Eligibility Verification System, and/or a monthly eligibility report, please contact Concierge Services for further assistance.

Sample Member ID Card:



Privacy Practices

ApexHealth is regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. In accordance with these regulations, ApexHealth provides a Notice of Privacy Practices on our website, which describes member rights and responsibilities to safeguard protected health information.

While providers must have their own Notice of Privacy Practices per the HIPAA Privacy Rule, a copy of our Privacy Practices may be accessed on our website at www.**apex**health.com/notice-of-privacy-practice/.

You may contact the ApexHealth Privacy Officer with any questions or concerns regarding a member's privacy or if you wish to file a privacy related complaint.

Attn: Privacy Officer

ApexHealth

96 Kercheval Avenue Suite 200

Grosse Pointe Farms, MI 48236

Member Rights and Responsibilities

ApexHealth Members have the following rights and responsibilities:

- Members have a right to receive information about the managed care organization, their services, their practitioners and providers, and the member's rights and responsibilities.
- Members have a right to privacy and to be treated with respect and dignity.
- Members have a right to participate with practitioners in decision-making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to file complaints or appeals about the managed care organization or the care provided.
- Members have a right to make recommendations regarding the organization's member's rights and responsibilities policies.
- Members have a right to change their Primary Care Provider (PCP) at any time.
    - Changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month.
- Members have a responsibility to provide, to the extent possible, information that the managed care organization and their practitioners and providers need to care for them.
- Members have a responsibility to follow the plans instructions for care that they have agreed on with their practitioners, including referral and authorization rules.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Members have the right to receive information in a way that works for them.
    - ApexHealth provides member materials in alternate formats, languages other than English, and provides a language line for members who speak languages other than English.
- Members have the right to get timely access to covered services.

- Members have the right to direct access through self-referral: screening mammography, influenza vaccine, and pneumococcal vaccine through contracted providers at no cost.
- Members have a right to adequate access to plan providers, and as such ApexHealth will maintain and monitor a network of providers including, but not limited to: Primary Care Providers (PCPs), Specialists, Hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies, Ambulatory Clinics, and other providers.
    - Furthermore, ApexHealth will ensure members have access to network providers that can furnish all plan benefits, including supplemental benefits. If a network provider cannot perform a medically necessary service for a member, ApexHealth will arrange for an out-of-network provider to furnish the service.
- Members have a right to direct access to an in-network women's health specialist without having to obtain a referral from their PCP or plan authorization.
- Members have the right to out-of-network specialty care if a network provider is unavailable or inadequate to meet a member's medical needs.
- Members have the right to a continuation of benefits for the contract period the plan has with CMS.
    - Furthermore, if a member is hospitalized on the date the plan's contract ends with CMS, the plan will still be responsible to furnish a continuation of benefits per ApexHealth's contractual obligation with CMS.
- Members have a right to receive upon enrollment and, annually thereafter, and Evidence of Coverage (EOC) that explains all plan benefits, rights and responsibilities of the plan, and the rights and responsibilities of the member.
    - This includes, but not limited to, appeal rights, cost sharing and plan premium responsibilities, and how to locate and select providers within the ApexHealth network. Members can call Concierge Services if they have questions about their rights and responsibilities, think they are being treated unfairly, or want more information about the plan.
- Members have the right to be notified at least 30 days in advance before a provider that they are currently receiving care from is terminated. ApexHealth will assist the member in finding a new provider prior to the termination date of their currently assigned health care professional.

ApexHealth staff and contracted providers must comply with all requirements concerning member rights.

Advanced Directives

ApexHealth providers are responsible for maintaining written policies and procedures regarding Advance Directives, educating members regarding Advance Directives, providing members with Advance Directive forms, and obtaining forms from members for attachment to the member's medical record. Providers must have written information available to members explaining their rights while describing the provider's role and limitations in implementing the Advance Directive. Whether or not the individual has executed an advance directive must be documented and maintained in a prominent part of each member's health record.

Credentialing and Re-credentialing

ApexHealth has written policies and procedures for the credentialing and recredentialing of physicians, other licensed independent practitioners, and Health Delivery Organizations (HDO) which fall under its scope of authority. ApexHealth ensures initial credentialing and recredentialing processes are conducted in accordance with standards established by, but not limited to, Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and applicable State Administrative Codes. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements.

For physician group practices, physician hospital organizations (PHOs), independent physician associations (IPAs), etc. CMS requires copies of the arrangements/contracts between the contracting entity and the providers covered under the Medicare Advantage agreement with ApexHealth. CMS requires copies of each of these downstream contracts as part of the application to apply for a Medicare Advantage contract with CMS.

The provider credentialing and re-credentialing processes require that all providers keep the ApexHealth Provider Service Credentialing Team updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

All providers shall be notified within 15 days of any substantial discrepancies between credentialing verification information obtained by ApexHealth and information submitted by the provider. The applicant shall have 15 days to respond in writing to the ApexHealth Provider Service Credentialing Team regarding discrepancies.

ApexHealth re-credentials each provider in the network within thirty-six (36) months from the last credentialing cycle unless a shorter timeframe is required by applicable law. Approximately six (6) months prior to the provider's thirty-six (36) month anniversary date, the provider will be notified of the intent to re-credential. All necessary forms will be sent for completion. In certain instances, a site visit will be scheduled with the provider.

Additionally, the provider re-credentialing process includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Provider Rights

Applicants have the right to review information submitted to support their credentialing application. Practitioners may review any documentation submitted in support of their credentialing or re-credentialing application, together with any discrepant information relating, but not limited to:

- Education or training
- Liability claims history
- State licensing
- Certification boards
- Professional societies
- Accreditation

Peer review information obtained by ApexHealth during the credentialing and re-credentialing process may not be reviewed unless required by law.

In the event the credentials verification processes reveal information submitted by provider differs from the verification information obtained by ApexHealth, the practitioner is allowed to submit corrections in writing for the erroneous or conflicting information.

The practitioner will be notified if significant discrepancies are found by ApexHealth in writing within fifteen (15) calendar days. ApexHealth's notification communication will include:

- The nature of the discrepant information
- The process for correcting erroneous information submitted by another
- The format for submitting corrections
- The timeframe for submitting the corrections
- The addressee to whom the corrections must be sent
- ApexHealth's process for receipt of the corrected information
- ApexHealth's review process

Providers have the right to receive the status of their application. Upon receipt of a written request, ApexHealth will provider practitioners with the status of their credentialing or re-credentialing application within fifteen (15) calendar days. The information provided will advise of any items missing, still needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared to information provided by them.

Status requests can be sent electronically to providers@apexhealth.com or in writing to ApexHealth. Inquiries should include the applicant's name, NPI, CAQH ID (if applicable), Tax Identification Number, and description of inquiry.

Mail To: Attn: Credentialing

96 Kercheval Avenue Ste 200

Grosse Pointe Farms, MI 48236

Provider Credentialing Appeal Process

There is a formal method of appeal for a provider/applicant who is denied participation within the ApexHealth Provider Network. The request for reconsideration or appeal must be submitted to the ApexHealth Provider Service Credentialing Team, who will submit the information to the Credentialing Committee.

- The provider/applicant who is denied participation in the ApexHealth Provider Network may submit a request for reconsideration, within 30 days of the date of their participation denial, with additional supportive information or evidence of his/her professional qualifications or abilities to meet the accepted credentialing criteria.
- Providers shall submit their written request for appeal and hearing via registered mail, return receipt requested to:
    - Status request can be sent via electronically to providers@apexhealth.com or in writing to ApexHealth. Inquiries should include the applicant's name, NPI, CAQH ID (if applicable), Tax Identification Number and details relevant to the appeal.

Mail To: Attn: Credentialing

96 Kercheval Avenue Ste 200

Grosse Pointe Farms, MI 48236

- The request for reconsideration and the additional information will be submitted to the Credentialing Committee at the next scheduled meeting date.
- The Credentialing Committee will review the appeal request, with the supporting documentation, and will make a final determination of the appeal.
- The appealing provider/applicant will be notified of the appeal determination by the Credentialing Committee through the Medical Director or assigned designee by certified letter within 30 calendar days of the Credentialing Committee meeting.
- If the denial is overturned, the provider/applicant will continue with the new participation notification process.
- Denied applications are maintained in a confidential manner within a Denied Participation file and are maintained by ApexHealth. Denials of participation are kept confidential except where reportable by ApexHealth under Federal or State regulation.

Access and Availability Requirements

ApexHealth contracted providers and practitioners are responsible and accountable to ApexHealth members twenty-four (24) hours a day, seven (7) days a week. Providers will be expected to abide by State and Federal standards of timeliness of access to care and services based on the urgency of the member's needs and when medically necessary.

The following guidelines will be continuously monitored to ensure compliance to these standards within the network.

- Primary Care Physicians (PCPs) and specialists must be available to address member medical needs twenty-four (24) hours a day, seven (7) days a week. The PCP may delegate this responsibility to another ApexHealth physician or provider on a contractual basis for after-hours, holiday, and vacation coverage. Voicemail alone is not acceptable.
- If the PCP or specialist site utilizes a different contact phone number for an on-call or after-hours service, the PCP site must provide ApexHealth with the coverage information and the contact phone or beeper number. Please notify the ApexHealth Provider Services Department with any changes in PCP medical care coverage.
- PCPs may employ other licensed physicians who meet the credentialing requirements of ApexHealth for member coverage as required and necessary. It is the responsibility of the PCP to notify ApexHealth each time a new physician is added to the PCPs practice to assure that all physician providers are credentialed to ApexHealth standards. PCPs may employ licensed/certified Physician Assistants (PAs) or Registered Nurse Practitioners (RNPs) to assist in the care of management of their patient practice. If PAs or RNPs are utilized, the PCP or the designated and credentialed physician, must be readily available for consultation via telephone or beeper within a fifteen (15) minute call back time. The PCP or designated and credentialed physician must be able to reach the site where the PA or RNP is located within thirty (30) minutes.
- Non-professional health care staff shall perform their functions under the direction of the licensed PCP, credentialed physician, or other appropriate health care professional such as a licensed Physician Assistant (PA) or a Registered Nurse Practitioner (RNP).

IMPORTANT: Failure to provide twenty-four (24) hour medical coverage and/or make the appropriate arrangements for member medical coverage constitutes as a BREACH of the ApexHealth Practitioner Agreement, placing the provider at risk of due consequences.

ApexHealth recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for

medical care access; however, in the normal course of providing medical care, provider offices should regularly meet these expectations. Office hours offered to ApexHealth members must be the same hours made available to other insurance types, such as commercial products.

In addition, the following requirements must be met:

Office Visit Appointments

- Emergency Services are available immediately
- Urgently needed (non-Emergency) services are scheduled immediately
- Routine and symptomatic appointments are scheduled within 48-72 hours
- Preventive care appointments are scheduled within 30-45 calendar days
- Non-urgent visits are scheduled within 1 week

Behavioral Health Office Visit Appointments

- Life Threatening Emergency appointments are scheduled immediately
- Non-life-threatening emergency/urgent visits are scheduled within 6 hours
- Urgent visits are scheduled within 48 hours
- Initial routine office visits are scheduled within 10 business days
- Follow-up routine visits are scheduled within 14 business days

Office Waiting Time

To assure that members have timely access to patient care and services, ApexHealth providers are expected to monitor waiting room times on a continual basis. PCP offices will be surveyed periodically regarding this process. Member waiting room times should be less than thirty (30) minutes to be seen by a provider with no more than six (6) scheduled appointments made for a provider per hour. Supervising providers may routinely account for more than six (6) visits. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to book the member for another appointment.

After-Hours Access Standards

ApexHealth has established acceptable mechanisms for use by PCPs, specialists, and behavioral health providers to ensure telephone access and service for members twenty-four (24) hours a day. All practitioner agreements require providers to supply members with access to care twenty-four (24) hours a day, seven (7) days a week.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call beeper
- Call forwarding to provider's home or other location
- Recorded telephone message with instructions for urgent or non-life-threatening conditions, as well as instructions to call 911 or go to the nearest emergency room in the vent of a life-threatening condition or serious trauma.
    - This message should not instruct members to obtain treatment at the emergency room for non-life-threatening emergencies.

Facility Site Review

As part of the ApexHealth annual monitoring audits, a sampling of provider office facilities will be evaluated against ApexHealth site review and medical record keeping requirements. An overview of the guidelines for these site reviews are provided in the table below.

Guidelines for ApexHealth Facility Site Reviews
Access to Service
☐ Is each PCP available 20 hours per week ☐ Is the physician available 24 hours a day/7 days a week ☐ Does the practitioner have mechanisms in place to meet ApexHealth after-hours access standards
Provisions for Persons with Disabilities
☐ Are there designated handicap parking spaces close to the building entrance ☐ Is the building entrance accessible by wheelchair, walker, etc. ☐ Are office hallways, doorways, and bathrooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance) ☐ Are doors able to be operated by persons with physical limitations ☐ Are there accommodations for sign or hearing-impaired patients
General Office Appearance
☐ Are NO SMOKING signs & Patient's Rights posted ☐ Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.) ☐ Staff is aware of the confidentiality policy of the office ☐ Are restroom facilities available for waiting patients ☐ Are hours of operation posted ☐ Are all public and patient care areas clean, orderly, and ample enough to accommodate patients ☐ Teaching literature is available for the patient
Staff Competency
☐ Personnel file for each employee contains a copy of their current licensure, if applicable, or documentation of their formal training or certification ☐ Each personnel file contains documentation of orientation to the facility, duties of their position, office medical equipment, and procedures ☐ Each personnel file contains documentation of regular evaluations ☐ There is documentation of on-going education for all staff (office in-services, staff meetings, conferences, etc.) ☐ There is documentation of annual OSHA training for Blood borne Pathogens/Hazardous materials ☐ Job descriptions are available for each position ☐ Staff has current CPR Training ☐ There is documentation of acceptance or denial of Hepatitis B Immunization
Documents
☐ Current CLIA License ☐ Written Medical Waste Plan reviewed annually ☐ Current Radiology Registration ☐ Written Emergency Preparedness and Disaster Plan with disaster drill documentation ☐ Copies of appropriate MSDS sheets for the office ☐ Blood borne Pathogen Exposure Control Plan ☐ Manifests from Material Waste Processing Company ☐ Documented Quality Improvement Efforts ☐ Documentation of Well Water Safety, if applicable ☐ Documentation of Septic System Maintenance, if appropriate ☐ Documentation of quarterly fire drills and annual disaster drill
Policies
☐ Confidentiality

- ☐ Conflict Resolution
- ☐ Staff Competency & Orientation
- ☐ Medication storage and administration (including Narcotics and method to dispose of expired medication)
- ☐ Infection Control
- ☐ Radiology (pregnancy, safety apparel, maintenance of equipment, use of dosimeters, verification of proper technique, etc.)
- ☐ Maintenance of medical equipment (plan for broken equipment and routine maintenance and calibration – including Emergency Box, if appropriate
- ☐ Staffing plan (to include call-in vacation coverage and delegation of responsibilities)
- ☐ Pursing and storing of records
- ☐ Sterilization/High Level Disinfectant
- ☐ Advance Directives
- ☐ Abuse and Neglect
- ☐ Policy for reporting communicable diseases to the State
- ☐ Sentinel Events
- ☐ Documentation of 'no show' follow-up and phone contacts

Medications

- ☐ All stock and sample medications stored in a secure area away from patient access and in an appropriate location (shelf, refrigerator)
- ☐ No oral and injectable medications stored together
- ☐ Documentation of regular review of all medications for expiration dates
- ☐ A log is kept of all sample medications that are dispensed – including patient name, drug, lot number, and name of person giving the medication
- ☐ Multi-dose vials are marked with the initials of the person opening the vial and the date opened
- ☐ Medications and laboratory specimens stored in separate refrigerators
- ☐ All narcotics are stored under double lock system and the key is secure
- ☐ A narcotic log is maintained each working day – including current number of each item, name of drug and dosage given, name of the patient given the medication, date, medication given, and the number of doses remaining. All wastage should be documented. Any count should be accomplished using two staff persons.
- ☐ No medication identified for an individual is stored with stock medication
- ☐ Medication is not stored in a refrigerator with food or drink and a temperature log for the fridge is maintained (Staff should be aware of the proper temperature to be maintained)
- ☐ The office participates in the Vaccines for Children Program and submits data to the NCIR and SCIR database

Diagnostic Medical Equipment

- ☐ Thermometers
- ☐ Pulse Oximetry
- ☐ EKG Machine
- ☐ Colposcopy Equipment
- ☐ Ultrasound Machine
- ☐ Peak Flow Meter
- ☐ Glucometer
- ☐ Treadmill
- ☐ Oxygen Tanks
- ☐ Aerosol Machines
- ☐ Cryocautery Machine
- ☐ Autoclave
- ☐ Other

☐	Equipment manuals are available for all medical equipment
Safety	
☐	All emergency exits are indicated. Emergency lights and electric exit signs are in working order
☐	Universal precautions are always observed
☐	Fire extinguishers are inspected at least annually and have current markings
☐	Staff are aware of the location of fire pulls and fire extinguishers
☐	All fire exits are free of obstruction on both sides of the door (open all doors to check)
☐	Staff have been educated regarding the use and accessibility of MSDS sheets
☐	Appropriate staff have received annual Blood borne Pathogen Training and are aware of the Exposure Control Plan
☐	Appropriate protective apparel is provided (gowns, marks, gloves, face shields, etc.)
☐	All gases are stored in an appropriate manner (intact tanks, upright, and secured position. Staff are aware of the process for determining volume
☐	Sharps containers are used and discarded when ¾ full (disposed of with biohazard material) and not within reach of children
Laboratory	
☐	Quality checks are done and documented on each Waived Lab Test each day used
☐	No food, drink, or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container)
☐	No lab reagent is kept or used beyond its expiration date (proper disposal)
☐	All specimens are discarded in the proper manner after use
☐	All specimens should be labeled with the patient's name or ID number when multiple specimens are being tested
X-Ray	
☐	Pregnancy precautions for X-rays are posted
☐	Protective apparel is available and maintained – including dosimeters
☐	Written plan for disposal of old films and developing agents
☐	X-ray room is identified with a system to protect other staff from exposure
Sterilization and/or High-Level Disinfectant	
☐	All items to be sterilized or disinfected are first cleaned with an enzymatic detergent, dried, and then processed maintaining a soiled to clean workflow
☐	Sterilized items are packaged appropriately, marked with a chemical test strip, the date processed, an expiration date, and then stored in the appropriate manner
☐	A log documenting each run and the chemical test trip is maintained – including the date and the signature of the person processing the run
☐	A monthly spore check is done and documented
☐	All containers holding chemical solutions are marked with the name of the solution, date of the expiration, and the date the solution was mixed
☐	Solution strength documentation exists for each day the solution is used
☐	Staff are aware of when sterilization with autoclave vs high-level disinfectant should be done
☐	Glass thermometers are cleaned with alcohol and disposable probe covers are used for electronic thermometers
☐	Work surfaces soiled with biohazard materials are wiped down with commercial disinfectant material or a 10% bleach solution after the completion of testing
☐	There are sinks with soap and paper towels available in patient care areas (bar soap on the sink is not acceptable). Liquid hand disinfectants may be used in instances where the activity has taken place in an area not supplied with a sink and then hands are washed as soon as a sink is available
☐	Hand washing is an expected practice before and after each patient encounter
☐	No food or beverage is consumed in any work area

☐ All equipment and surfaces cleaned appropriately after patient use ☐ Staff are aware of the process for reporting communicable diseases to the State ☐ Staff have been educated for the instance of tuberculosis (TB) and the screening process
Exam Room(s)
☐ Each room assures patient privacy ☐ No medications, needles, or syringes are stored in exam rooms unless in a locked cabinet ☐ Exam room is childproofed as appropriate (electrical outlet covers, no harmful solutions within reach, etc.) ☐ Area is clean and organized with opaque bags in wastebaskets ☐ No patient care supplies, or cardboard boxes are stored on the floor or under the sinks ☐ There is an 18-inch clearance for sprinkler heads ☐ Clean laundry is covered ☐ No outdated material is stored within room(s)
Medical Records
☐ The medical record is retrievable for review for 10 years ☐ Patient information is kept confidential. Files are maintained away from the accessibility of other patients, as are fax machines. Desktops do not have identifiable information in sigh of other patients. Sign-in sheets are not left in view of others ☐ There is an established organization of the medical record, with dividers by type of service - i.e., Lab, X-ray, consultations, discharge summaries, preventive services, progress notes, durable power of attorney/advance directives, informed consent, etc. ☐ All diagnostic and therapeutic services for which the practitioner referred the member are documented in the chart (Home Health Nursing Reports, Consults, Hospital discharges, Physical Therapy, etc.) ☐ There is a Problem List of significant illnesses and medical conditions with date of onset ☐ Medication allergies and adverse reactions or no known drug allergies (NKDA) are prominently displayed in the medical record ☐ A past medical history for patients seen more than 3 times that is easily identified – includes serious accidents, operations, and illnesses. For children 18 and under, past medical history relates to prenatal care, birth, operations, and childhood illnesses ☐ The medical record is a unit record ☐ There is an appropriately signed and dated Release of Information (ROI) in the medical record ☐ The entries in the medical record are legible ☐ The entries in the medical record are signed and dated by the author ☐ There is an acknowledgment of receipt of privacy notice in the record – if not an individual record, there is a central file with the acknowledgement of receipt of notice

OSHA Training

Employee training and annual in-service education must include:

- Universal precautions
- Proper handling of blood spills
- Hepatitis B (HBV) or Human Immunodeficiency Virus (HIV) transmission and prevention protocol
- Needle stick exposure and management protocol
- Blood borne Pathogen Training
- Sharps handling
- Proper disposal of contaminated materials
- Information concerning each employee's at-risk status

At-risk employees must be offered Hepatitis B (HBV) vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for Hepatitis B (HBV) vaccines. Personal protective equipment must be provided to each at-risk employee. Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

- Pharmacy Drug Control license issued by the State if dispensing drugs other than samples
- Section 17757a from the Board of Pharmacy if dispensing drugs other than samples
- Controlled Substances License from the State and the Federal Drug Enforcement Administration (DEA)
- Clinical Laboratory Improvement Amendments (CLIA) Certification of Waiver
- Medical Waste Management Certificate
- X-ray equipment registration
- R-H 100 Notice
- Radiology protection rules
- OSHA poster (#2010)

Provider Roles and Responsibilities

CMS requires providers to provide care to Medicare Advantage members in a culturally competent manner, being sensitive to language, cultural, and reading comprehension capabilities. ApexHealth offers a language service to anyone speaking a non-English language. There is no charge to members for this service. To access this service for any health plan Medicare Advantage members in your practice, please contact Concierge Services and ask for language services.

Providers must ensure that their houses of operation are convenient for the aged, disabled, chronically ill, and low-income populations that they serve. Providers must provide all plan benefits covered by Medicare and by ApexHealth in a manner consistent with professionally recognized standards of health care.

Providers must also ensure continuity of care and develop procedures that guarantees members are informed of their health care needs that require follow-up visits or provide training in self-care as necessary.

Providers must provide to ApexHealth, upon request, a member's medical records to support complete and accurate risk adjustment data and the validation of risk adjustment data for auditing purposes.

Providers shall not distribute any marketing materials that mention ApexHealth or include ApexHealth logos without first obtaining approval from both ApexHealth and CMS. Providers must comply with all CMS marketing requirements in Chapter 3 of the Medicare Managed Care Manual.

Primary Care Provider (PCP) Roles and Responsibilities

Each ApexHealth Medicare Advantage member selects a Primary Care Provider (PCP), who is responsible for coordinating the member's total health care. Primary Care Providers (PCPs) are required to work twenty (20) hours per week (per location) and be available twenty-four (24) hours a day, seven (7) days a week.

With the exception for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or ApexHealth.

Specialty Care Physician Roles and Responsibilities

ApexHealth recognizes that the specialty physician is a valuable team member in delivering care to ApexHealth members. Some of the key specialty physician roles and responsibilities include:

- Rendering services requested by the PCP
- Communicating with the PCP regarding member findings in writing
- Obtaining prior authorization from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within sixty (60) days of the consult
- Providing the lab or radiology provider with:
    - The PCP and/or Corporate prior authorization number
    - The member's ID number

Hospital Roles and Responsibilities

ApexHealth recognizes that the hospital is a valuable team member in delivering care to ApexHealth members. Some essential hospital responsibilities include:

- Coordination of discharge planning with ApexHealth Medicare Utilization Management staff
- Coordination of mental health/substance abuse care with the appropriate State agency or provider
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to ApexHealth and to the PCP
- Communication of all hospital admissions to the ApexHealth Medicare Utilization Management staff within one (1) business day of admission
- Issuing all appropriate service denial letters to identified members

Ancillary/Organization Provider Roles and Responsibilities

ApexHealth recognizes that ancillary providers are another valuable team member in delivering care to ApexHealth Medicare members. Some of the critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions, and/or benefit extensions applicable to ApexHealth members
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to ApexHealth and to the assigned PCP.

Confidentiality and Accuracy of Member Records

Medical records and other health and enrollment information of a member must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular member
- Maintain such records and information in a manner that is accurate and timely
- Respect member rights, such as access to, amend errors in, request confidentiality for, or an accounting of disclosures, the member's health information
- Identify when and to whom the member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member
- Maintain such records and information in a manner that is accurate and timely
    - Ensure timely access by enrollees to the records and information that pertain to them for what purpose(s) the information will be used within the organization
    - Identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy of any information that identifies a particular member, the health plan, including participating providers, is obligated to abide by all Federal and State laws regarding

confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, provide information as requested within appropriate requested timeframes, and maintain records for a minimum of ten (10) years.

Obligations of Recipients of Federal Funds

Providers participating in ApexHealth plans are paid for their services with federal funds and must comply with all requirements of laws applicable to receipts of federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

ApexHealth is prohibited from issuing payment to a provider or entity that appears in the List of Excluded Individuals/Entities published by the Department of Health and Human Services Office of Inspector General or in the System for Award Management published by the General Services Administration.

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at oig.hhs.gov/fraud/exclusions/database.html.
- The General Services Administration List of Debarred Contractors can be found at https://sam.gov/content/exclusions.

Health Plan Disclosures to CMS

ApexHealth is required to provide to CMS all information that is necessary for CMS to administer and evaluate the program. ApexHealth is also required to provide information to CMS that would allow CMS to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining their Medicare services. As a contracted provider with ApexHealth you are required to comply with ApexHealth's request for information to meet disclosure obligations to CMS. Types of disclosures to CMS by ApexHealth include, but are not limited to, plan disenrollment rates for the previous two (2) years, enrollee satisfaction results, health outcome information, recent compliance records of the plan, and any other information that may be necessary for CMS to assist beneficiaries in making an informed health plan choice.

Billing and Claims Payments

Claims must be submitted using the proper claim form/format, e.g., for paper claims, submit a CMS 1500 or UB-04 form; for electronically submitted claims through Electronic Data Interchange, claims must be submitted via an ASC X12 837 professional claim or ASC X12 837 institutional claim file meeting the 2010 HIPAA EDI standards. It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service.

Billing Requirements

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to ApexHealth
- Providers may also submit and check the status of claims electronically via the secure Provider Portal
- Claim must be original, using national or State form types as applicable. Photo or scanned copies are not accepted. The claim information must be typed, with no hand-written information other than applicable signatures
- Taxonomy code must be included in ALL claims

Claims Submission Requirements

Electronic Claims should be submitted through your EDI partner utilizing the ApexHealth **Payer ID 83112**

Submit all initial Paper claims for payment to:

ApexHealth

P.O. Box 981802

El Paso, TX 79998-1802

Billing Procedure Code Requirements

ApexHealth requires that providers use HCPCS, CPT, ICD-10, and revenue codes when billing ApexHealth.

Explanation of Payments

ApexHealth sends remittance vouchers to providers as a method of Explanation of Benefits (EOBs).

Balance Billing Prohibited for Medicare Eligibles

You may not balance bill for services and supplies furnished to ApexHealth members. Members are only responsible for their cost-share when receiving plan covered services. Any difference between what you bill and what ApexHealth pays cannot be billed to the member.

Additionally, you may not bill for services and supplies furnished to Qualified Medicare Beneficiaries (QMBs); for these beneficiaries, Medicaid is responsible for premiums, deductibles, coinsurance, and copayment amounts for Medicare Part A and Part B covered services. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. Billing prohibitions may also apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Medicare Part A and Part B cost-sharing.

Note: The prohibition on collecting Medicare cost-sharing is limited to services covered under Medicare Part A and Part B. Low-Income Subsidy copayments still apply for Part D benefits.

Note: QMBs are sometimes called “dual eligible.” They are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100% of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office.

Payment to Non-Contracted Providers

In accordance with CMS requirements, ApexHealth will make timely and reasonable payment for certain services that are rendered by an out-of-network provider at a minimum rate that complies with the Original Medicare rates if the service is covered by the plan and performed on the member’s behalf.

Examples of reimbursable services obtained by an out-of-network provider are determined in accordance with 422.100(b), and include:

- Ambulance services dispatched through 911 or its local equivalent
- Emergency and urgently needed services
- Maintenance and post-stabilization care services

- Renal dialysis services provided while the member was temporarily outside the plan's service area
- Services for which coverage has been denied by ApexHealth and found, upon appeal, to be services the member was entitled to have furnished, or paid for, by ApexHealth

Provider Grievance & Appeals Process for Denied Claims

Contracted providers can request an appeal from ApexHealth when acting strictly on their own behalf and the member is not at financial risk, such as for an unapproved inpatient admission.

ApexHealth offers a post-service claims appeal process for disputes related to denial of payment for services rendered to ApexHealth Medicare members. This process is available to all providers, regardless of whether they are in or out-of-network.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

1. The provider disagrees with a determination made by ApexHealth, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information, such as medical records, that support the provider's position.
2. The provider is requesting an exception to an ApexHealth Medicare policy, such as prior authorization requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to member ineligibility on the date of service or non-covered benefits.

How to File a Post-Service Claim Appeal

- Please send a letter explaining the nature of your appeal and any special circumstances that you would like ApexHealth to consider
- Attach a copy of the claim and documentation to support your position, such as medical records
- Send the appeal to ApexHealth:

  Attn: Claims Appeals

  96 Kercheval Avenue Ste 200

  Grosse Pointe Farms, MI 48236

Timeframe for Filing a Post-Service Appeal

Claims must be filed within one (1) year from the date of service. The Claims Appeals Department will allow one hundred and twenty (120) days from the date of the last claim denial, provided that the claim was submitted within one (1) year of the date of service. Appeals submitted after the timeframe has expired will not be reviewed by ApexHealth.

Response to Post-Service Claims Appeals

The Claims Appeals Department typically responds to a post-service claim appeal within sixty (60) days from the date of receipt. Providers will receive a remittance with the Claim Appeals Department decision and denial reason.

There is only one (1) level of claims appeals available. All appeal determinations are final.

If you have any questions about the post-service claim appeal process, please call Concierge Services.

Provider Grievances

Both network and out-of-network providers may file a grievance verbally or in writing directly with ApexHealth regarding our policies, procedures, or any aspect of our administrative functions. Provider Grievances should be submitted to the Provider Services Department at providers@apexhealth.com or phone 1-844-279-0508.

Utilization Management

Authorization Overview

Authorization processing is the primary activity performed by our Utilization Management staff. For all authorization questions, please contact us at 844-279-0508.

Four easy ways to submit authorizations:

1. Electronically via the web-based eQ Provider Portal
2. Phone at 844-279-0508
3. Fax at 833-332-1877
4. Mail:

    ApexHealth

    Attn: Utilization Management

    96 Kercheval Avenue, Suite 200

    Grosse Pointe Farms, MI 48236

Please note the term “preauthorization” (prior authorization, precertification, preadmission) when used in this communication is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan as to whether an item or service will be covered. Preauthorization for certain services, drugs, and medical equipment are required for in-network providers. All non-emergent out-of-network provider services require prior authorization.

“Notification” refers to the process of the physician or other healthcare provider notifying ApexHealth of the intent to provide an item or service. ApexHealth requests notification, as it helps coordinate care for ApexHealth covered members. This notification process is intended for all providers.

Please visit https://apexhealth.com/providers/ for the ApexHealth authorization listing.

UM Decision Clinical Review Criteria

ApexHealth must review and approve all required services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, performed in the appropriate setting, and is a covered benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Utilization Management clinical staff use plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All Utilization Review decisions to deny

coverage are made by ApexHealth Medicare Medical Directors. In certain circumstances, external reviews of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

As a Medicare Advantage plan, we must cover all services and benefits covered by Original Medicare.

National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals (https://www.cms.gov/Medicare/Coverage/DeterminationProcess).

Local Coverage Determinations (LCDs)

LCDs provide guidance to the public and provider community within a specific geographical area. LCDs supplement a NCD or explain when an item or service will be considered covered if there is no NCD. A LCD cannot contradict a NCD.

In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals, ApexHealth may utilize current literature review, consultation with practicing physicians and medical experts in their particular field, government agency policies and standards adopted by a national accreditation organization, and Medical Management policies for decision-making. ApexHealth may also adopt the coverage policies of other Medicare Advantage Organizations in the service area.

It is the responsibility of the attending physician to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

Clinical information is required for all clinical review requests. To ensure timely decisions, make sure all supporting clinical information is included with the initial request. The preferred method of clinical review submission is via fax. If the clinical information is not received with the request, the ApexHealth Utilization Management staff will send a fax request for the information and/or contact the physician or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member's:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Member's response to treatment
- Discharge disposition

Clinical information should be provided at least fourteen (14) days prior to the service unless services are urgent. The facility is responsible for ensuring authorization. ApexHealth provides a request ID on all authorizations.

Inpatient Review

Our nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care. ApexHealth nurse reviewers assess the care and services provided in inpatient settings and the member's response to the care by applying InterQual® criteria. Together with the facility's staff, care management's clinical staff coordinates the member's discharge needs.

All elective hospital admissions initiated by the PCP or specialist requires a prior authorization. You may call Concierge Services, enter the authorization request via the ApexHealth Provider Portal, or fax requests to us. Be sure to include documentation of medical necessity to facilitate the earliest possible turnaround time. The facility is responsible for ensuring authorization.

Processing Timeframes

Request Type	Decision Timeline	Notification	Denial Notification
Non-Urgent Pre-Service	Within 14 days of receipt of the request	Within 14 days of receipt of the request	Written denial notification within 14 days of receipt of the request
Non-Urgent Pre-Service Part B Drug	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Written denial notification within 72 hours of receipt of the request
Urgent Pre-Service	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Written denial notification within 72 hours of receiptof the request
Urgent Pre-Service Part B Drug	Within 24 hours of receipt of the request	Within 24 hours of receipt of the request	Written denial notification within 72 hours of receipt of the request, if verbal notification was given within 24 hours of receipt of the request
Urgent Concurrent	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Written denial notification within 72 hours of receipt of the request

Case Management

The ApexHealth Case Management Program provides member-focused, individualized case management for members who meet program criteria. The following case management programs are available to personally support the healthcare needs of members with asthma, diabetes, congestive heart failure, cardiovascular disease, complex/catastrophic illness, and high emergency room use.

Our case managers will send you a report identifying the member's health status along with short- and long-term goals for case management.

Our case managers may contact you for other reasons:

- To coordinate a plan of care

- To confirm a diagnosis
- To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing
- To identify compliance issues
- To discuss other problems and issues that may affect outcomes of care
- To inform you of a member's potential need for behavioral health follow-up

Member Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two types of complaints members can file. All contracted providers must cooperate with the Medicare Advantage appeals and grievances process.

Definitions

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the way a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may make a complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration timeframe.

Expedited Appeal: An expedited appeal is a request to change a denial decision for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement. Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and is, therefore, eligible for an expedited appeal.

Pre-Service Non-Urgent Appeal: Providers, acting on behalf of a member, may request an appeal of a denial in advance of the member obtaining care or services. ApexHealth will provide acknowledgement of the appeal within three (3) days of receipt of the request. No physician will be involved in an appeal for which he/she made the original Adverse Determination. No physician will render an appeal decision who is a subordinate of the physician making the original decision to deny.

Levels of the Appeals Process

The levels of the appeals process are listed below. If an appeal is not resolved at one level, it can proceed to the next.

1. Standard or expedited appeals process
2. Review by an Independent Review Entity (IRE)
3. Review by an Administrative Law Judge (ALJ)
4. Review by a Medicare Appeals Council (MAC)
5. Review by a Federal District Court Judge

Members can appeal a medical decision within sixty (60) calendar days of receiving the ApexHealth's letter denying the initial request for services or payment on their own behalf. They can also designate a representative, including a relative, friend, advocate, doctor, or other person to act for them. The member and the representative must sign and date a statement giving the representative legal permission to act on the member's behalf.

The member can call Concierge Services to learn how to name an authorized representative.

Appeals and Grievances

A member may appeal an adverse initial decision by ApexHealth or a participating provider concerning authorization for or termination of coverage of a health care service. A member may also appeal an adverse initial decision by ApexHealth concerning payment for a health care service. A member's appeal of a decision about authorizing health care or terminating coverage of a service must generally be resolved by ApexHealth within thirty (30) calendar days or sooner if the member's health condition requires. An appeal concerning payment must generally be resolved within sixty (60) calendar days.

Participating providers must also cooperate with ApexHealth and members in providing necessary information to resolve the appeals within the required timeframes. Participating providers must provide the pertinent medical records and any other relevant information to ApexHealth. In some instances, participating providers must provide the records and information very quicky to allow ApexHealth to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's physician can request an expedited appeal. Such appeal is generally resolved within seventy-two (72) hours unless it is in the member's interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

A special type of appeal applies only to hospital discharges. Hospitals are required to notify all ApexHealth Medicare members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the Important Message from Medicare About Your Rights (IM), a statutorily required notice, up to seven (7) days before admission, or within two (2) calendar days of admission, obtain the signature of the member or of his/her representative, and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of the discharge as possible but not less than two (2) calendar days before discharge.

If the member thinks their hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization which is contracted with CMS; however, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that ApexHealth coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from ApexHealth.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facilities (SNFs), home health agencies (HHA), or comprehensive outpatient rehabilitation facility services (CORF). Medicare regulations require the provider to deliver the standard Notice of Medicare Non-Coverage (NOMNC) to all members when covered services are ending, whether the member agrees with the plan to end services or not. Providers must distribute the NOMNC at least two (2) days prior to the enrollee's CORF or HHA services ending and two (2) days prior to the termination of SNF services. If the member thinks his/her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization. If the member gets the notice two (2) days before coverage ends, the member must request an appeal to the Quality Improvement Organization no later than noon of the day after the member gets the notice. If the member gets the notice more than two (2) days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to the Quality Improvement Organization, the member can request an expedited appeal from ApexHealth.

ApexHealth encourages all members and providers to contact the plan to report concerns. If a member has a grievance about their plan, a provider, or any other issue, the member can contact ApexHealth in the following ways: Calling Concierge Services, accessing the plan's website, or in writing to file a grievance.

ApexHealth will send an acknowledgement letter within three (3) calendars days of receiving a grievance request. The plan must investigate and resolve a member's grievance within twenty-four (24) hours for urgent grievances and within thirty (30) calendar days for standard grievances. We may extend the timeframe by up to fourteen (14) calendar days if the member requests the extension or if we can justify a need for additional information and the delay is in the member's best interest.

Further Appeal Rights

If ApexHealth denies the member's appeal in whole or in part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of ApexHealth. This organization will review the appeal and, if the appeal involves authorization for health care services, formulate a decision within thirty (30) days. If the appeal involves payment for care, the IRE will make the decision within sixty (60) days. If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may appeal to a Federal District Court of the United States.

First-Tier, Downstream, and Related (FDR) Entities

As a participating provider (individual, group, facility, or ancillary, etc.) in our Medicare Advantage Prescription Durg (MA-PD) plan, you must meet the CMS compliance program requirements for first-tier, downstream, and related (FDR) entities and attest to your compliance annually.

We provide several resources to help you comply and attest to your compliance with these requirements, including:

- Our code of conduct and compliance policies that you can adopt
- Access to our hotline to report non-compliance
- An FDR Guide that walks you through each requirement
- Answers to questions we often receive from FDRs, like you

How to Complete Your Attestation

You will find the attestation, as well as the resources mentioned above, on our dedicated web page at www.apexhealth.com/FDR under "FDR Annual Attestation."

Where to Get More Information

If you have attestation completion or compliance-related questions and do not find the answer(s) in what has been provided, email us at FDR@apexhealth.com

Fraud, Waste, and Abuse

Healthcare fraud, waste, and abuse affect everyone one of us. It is estimated to account for between 3% - 10% of the annual expenditures for health care in the United States. Healthcare fraud is both a State and Federal offense.

Generally, fraud, waste, and abuse (FWA) are defined as:

Fraud: An intentional deception or misrepresentation made by a person who knows, or should know, that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes as fraud under applicable Federal or State law.

Waste: Involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g., executive, judicial, or legislative branch employees, grantees, or other recipients). Waste goes beyond fraud and abuse. Most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions, and inadequate oversight.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Additionally, it includes recipient practices that result in unnecessary cost to the Medicare program.

Here are some examples of Fraud, Waste, and Abuse:

Fraud and Waste

- Providers billing for services not provided
- Providers billing for the same service more than once (i.e., double billing)
- Providers performing inappropriate or unnecessary services
- Altering a prescription written by a doctor
- The misuse of a Medicare card to receive medical or pharmacy services
- Making false statements to receive medical or pharmacy services

Abuse

- Going to the Emergency Department for non-emergent medical services
- Threatening or abusive behavior in a doctor's office, hospital, or pharmacy

Overpayment and Recovery

ApexHealth handles recovery of overpayments ("take-backs") according to the situation that created the overpayment and the timeframe between when the payment was made and when the overpayment was identified. Below are examples of overpayment and recovery situations:

- Inaccurate payment: This includes duplicate payment, system set-up error, claim processing error, and claims paid to the wrong provider
    - Adjustment/notification date for recovery will be limited to twelve (12) months from the date of payment
- Identified through a medical record audit
    - Adjustment/notification date for recovery will be limited to twelve (12) months from the date of payment. If the audit reveals fraud, waste, or abuse, the twelve (12) months look back period will no longer apply.
- Fraud and abuse
    - Adjustment/notification date for recovery will be the statute of limitations or the time limit stated in the Provider Agreement

In the event it is determined that an inaccurate payment was made, ApexHealth will not provide prior written notice of a recovery. In that case, ApexHealth will recover the overpayment by issuing an invoice or performing a take-back. Full details of this recovery will be provided in either the invoice or the remittance advice.

No time limit applies to the initiation of overpayment recovery efforts required by a State or Federal program or where there is suspected fraud or intentional misconduct involved.

To Report Possible Fraud, Waste, or Abuse:

Contact ApexHealth's Corporate Compliance Officer at.

ATTN: Compliance Officer

96 Kercheval Avenue, Suite 200

Grosse Pointe Farms, MI 48236

313-327-3288

Providers may also report potential Fraud, Waste, and Abuse to ApexHealth anonymously at apexhealth.ethicspoint.com, via phone at (844) 634-1167, or by scanning the QR code below.