OVATION HEALTH

THE FUTURE OF HEALTHCARE

Ovation Health Plan Provider Manual

2024

INTRODUCTION

Welcome to Ovation Health contracted with USA Primary Care IPA. Thank you for participating in our network.

This Provider Manual is a reference guide for your providers and staff providing services to our members who participate in Ovation Health Plans.

OVERVIEW

Ovation Health is a health plan that utilizes a contracted physician network (PPO), and open-access care (Reference-based Pricing)

Ovation Health Plans are designed to achieve these 6 objectives:

- Keep member health care costs transparent
- Advocacy on the member's behalf
- Affordability of services
- Compassion for members
- Innovation of healthcare
- Achieve high-quality health care

Ovation Health Plans takes the privacy and confidentiality of our member's health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations (when applicable). The services provided by the contracted USA Primary Care IPA network providers are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our members and their Primary Care Physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. The PCP is responsible for coordinating our member's health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the Member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

Ovation Health and USA Primary Care have the most important telephone and fax numbers, and email and physical addresses available to our providers and their staff at our web page https://www.ovation.health. When calling, to verify network status or member eligibility please try to have the following information available.

1. The Provider's NPI
2. The office NPI and Tax ID Number
3. The Member's Ovation Health member ID number

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING AND RECREDENTIALING

The credentialing and re-credentialing process exists to verify that participating practitioners and providers meet the criteria established by USA Primary Care, as well as applicable government regulations and standards of accrediting agencies. If a practitioner/provider already participates with USA Primary Care IPA for another product, the practitioner/provider will NOT be separately credentialed for the Ovation Health product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Ovation Health of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.
Whether a state utilizes a standardized credentialing form, or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation;
- Completed ownership and control disclosure form;
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage;
- Curriculum vitae listing, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants;
- Signed and dated release of information form not older than 120 days; and
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable, OR noted in file the lack of laboratory services on site.

The following must be available on request if not included in the practitioner's CAQH profile on the CAQH website.

- Current specialty board certification certificate,
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Ovation members;
- Completed and signed w-9 form

Ovation Health will primary source verify the following information submitted for credentialing and recredentialing:

- License through appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- Malpractice claims and license agency actions through the national practitioner data bank (NPDB);
- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General, Preclusion List).

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Recredentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the application is completed, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.
Practitioners/Providers must be credentialed prior to accepting or treating members. Primary care practitioners cannot accept member assignments until they are fully credentialed.

Credentials Committee

The Credentials Committee including the Medical Director, or their physician designee has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision. Site reviews are performed at PCP and OB/GYN provider offices and facilities when the member complaint threshold of two complaints in six months is met. A site review evaluates:

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

Re-credentialing

Ovation Health conducts practitioner/provider re-credentialing beginning after 24 months but no more than 36 months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Ovation Health conducts provider performance monitoring activities on all network practitioners/providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/providers in between credentialing cycles. Additionally, Ovation Health reviews monthly reports released by the state, CMS and Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Ovation Health Credential Committee that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Ovation Health to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentials Committee within thirty (30) days of the initial notification.

The Credentials Committee will then include this information as part of the credentialing or recredentialing process.

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Services Department at 346-701-5578.

Practitioner Right to Appeal Adverse Re-credentialing Determinations

Applicants who are existing providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within thirty (30) days of the date of the notice.

New applicants who are declined participation may request a reconsideration within thirty (30) days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentials Committee at the next regularly scheduled meeting and/or no later than sixty (60) days form the receipt of the additional documentation.

Provider Non-Discrimination

Ovation Health does not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility based solely on any characteristic protected under state or federal discriminate laws. We also do not discriminate for reimbursement or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. If Ovation Health declines to include individual or groups of providers in our network, we will give the affected providers written notice of the reason for its decision.

Furthermore, we do not and have never had a policy of terminating any provider who:

- advocated on behalf of a member
- filed a complaint against us
- appealed a decision of ours

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Primary Care Providers

The Primary Care Provider (PCP) is the foundation of Ovation Health's plan and care model. The PCP serves as the basis for all medical services for Ovation Members. This leads to an approach to care in which the PCP is the primary coordinate of all care for each member, and is holistic, patient-centered (with regards to approach(es) to treatment). Ovation believes that strong patient-provider relationships lead to better health outcomes. The PCP, therefore, is responsible for all primary care services for Ovation members, including, but not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation of referrals for medically necessary specialty care
- Maintaining continuity of care for each assigned member
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral

Ovation Patient Advocates will partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in building a patient-provider relationship, and co-ordinate care beyond the PCP's capability.

All PCPs may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member's choice, Ovation does not guarantee a PCP will receive a set number of patients. PCPs may contact Provider Services if they, choose to change their panel size or close their panel to accept only established patients. If Ovation determines that a PCP fails to maintain quality, accessible care, Ovation reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Member Selection of Assignment of PCP

Ovation gives members the freedom to select the health care provider of their choice, or the option to choose no PCP. Services from in-network, selected providers are covered based on contracted retainer agreement with the PCP's office or directly with the provider, with a rate of $30 per member per month, with a 6 visit limit from the member at $0 Copay OR Services from in-network, non-selected providers are covered based on contracted provisions, fee schedule, and any standard coding and claim guidelines, with exception of member cost sharing or co-pays (*See Plan Document for deductible, copay, and co-insurance then claims are then paid at Reasonable and Customary Medicare rates in the provider's zip code). Or until the Maximum Out of Pocket is met, out of network care is covered only in an emergency. Members are generally responsible for the full cost of care received from out of network providers.

SPECIALIST AS THE PRIMARY CARE PROVIDER

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. **Paper referrals are not required by Ovation Health**. In accordance with federal and state law, providers are

prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialty Care Provider

The Specialty Care Provider agrees to partner with the member's PCP and Care Manager to deliver care. Some key roles of specialty providers include:

- Rendering services requested by the PCP
- Communicating with the PCP regarding medical findings in writing
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult

Most visits to specialists do not require a prior authorization, for Contracted Specialists. While most specialists will require a written referral from the member's PCP, it is not required for the claim to be reimbursed by Ovation Health. Specialists may elect to limit their practice to established patients only upon request to Provider Services.

Members may self-refer to an OB/GYN for their annual well checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Obstetrics & Gynecology ("OB/GYN")
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Psychology and Psychiatry
- Pulmonology
- Rheumatology
- Urology

Hospitals

Hospitals are essential in delivering care to members. For this reason, Ovation may contract with hospitals in the member service areas; however, any facility can be used in the case of an emergency, unless excluded by plan sponsors. Additionally, Ovation contracts with rehabilitation facilities, ambulatory surgery center, and other facilities needed to manage the health care of its members. Some responsibilities of hospitals include:

- Coordination of discharge planning with Ovation Utilization Management staff

- Coordination of mental health /substance abuse care with the PCP and appropriate
- community providers
- Eligibility and benefit authorization before services are rendered
- Communication of all relevant medical information to member PCPs
- Communication of all emergent hospital admission to Ovation Patient Advocates staff within 48 hours of admission

Providers are encouraged but not required to have privileges at Ovation's contracted facility or agreements with hospitalist groups to care for their members who are hospitalized. Providers should review the Provider Directory for a list of contracted hospitals and associated facilities.

Ancillary Providers

Ancillary providers cover a wide range of services from therapy to laboratory services. The following are services provided by ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory – Ovation is Primarily contracted with Quest Diagnostics
- Prosthetics and Orthotics
- Diagnostic Imaging
- Therapy (Physical, Occupational, Speech)

Some critical areas of responsibilities for ancillary providers include:

- Obtaining member eligibility and benefit level prior to rendering services
- Know limitations and/or benefit exclusions applicable to member
- Communicate all relevant medical information to member’s PCP

APPOINTMENT AVAILABILTY

Telephone Arrangements

Provider Offices must be accessible to members during normal business hours, and Emergency Locations must be accessible 24 hours a day, seven (7) days a week.

- Primary Care and Non-Emergency Specialists/Ancillary Office Locations
    - Voice Mail or answering service required for After normal business hours.
    - All calls need to be returned within 1 business day.
- Emergency Centers (24hr Urgent Care and Hospital ER/ED)
    - Available at all times via
        - Direct Line to staff
        - Answering Service or Voicemail answered within 30 minutes.

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member's telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling cancelled and no-show appointments.
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally incapacitated.
- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours.
- Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method and transferred to the member's medical record.

Note: If after-hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Training Requirements

Ovation Network providers are required to keep record of training of staff for:

- HIPAA/HITECH (within 90 days of staff hire at least once yearly)
- CMS Fraud, Waste, and Abuse (within 90 days of staff hire at least once yearly)
- CMS Compliance training and monitoring (within 90 days of staff hire at least once yearly)
- Other training required by the State where the provider is in practice.

Training Materials for the above can be provided on request.

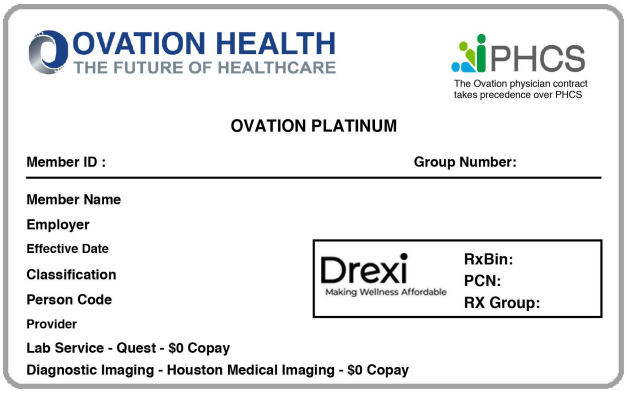
OVATION HEALTH BENEFITS

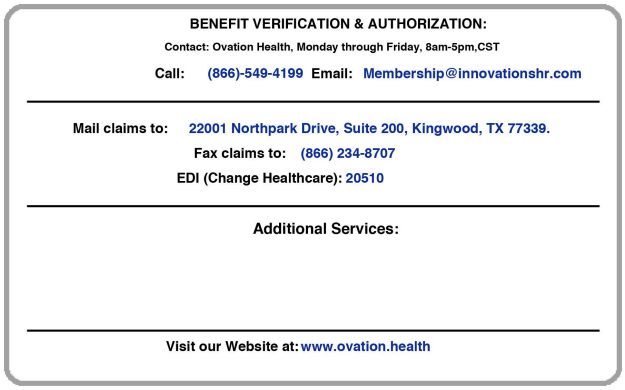
Ovation's Summary of benefits can be found on our website at https://www.ovation.health

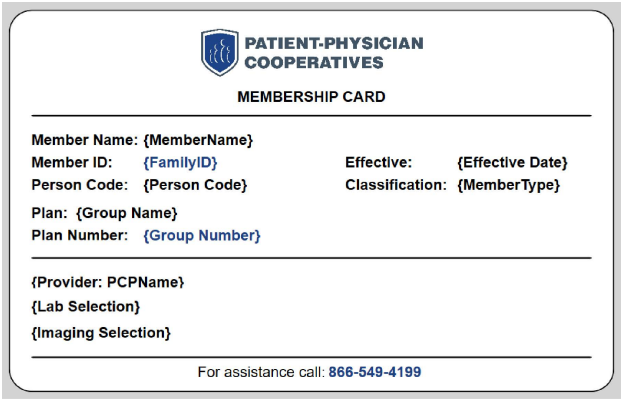
Verifying Member's Benefits and Coverage

For quick verification of benefits, please see the example cards. Some members may still have previous cards with PPC MVP500 plans (Green Card below). Members with an older card may not be eligible for benefits, if the member has presented an older card, or if your practice is unsure if the member is eligible based on the presented card, please call 866-549-4199 to verify benefits.

*See sample cards below







Prior Authorization

Prior authorization requires that the provider or practitioner make a formal medical necessity determination request to Ovation prior to the service being rendered. Members may submit a request for organization determination. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures/services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness review such as non-emergent inpatient admissions, all out-of-network services, and certain outpatient services,

ancillary services, and specialty injectable as described on the prior authorization list. Prior authorization is not required for emergency services or urgent care services.

Services Requiring Prior Authorization

To see a list of services that require prior authorization please call the Ovation Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. We will suspend the need for prior authorization requests during an emergency/disaster where providers are unable to reach Ovation for an extended period and when, acting in good faith, providers need to deliver services to our members. Ovation does not reward providers, practitioners, employees who perform utilization reviews, or other individuals for issuing denials of authorization, service, or care. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage.

Note: All out of network services require prior authorization excluding emergency room services, urgent care when the PCP is not available, and out of area dialysis.

Submitting Prior Authorization Requests

Prior authorization requests may be called to Ovation at 866-549-4199

Prior authorization requests may be faxed to 866-234-8707.

The requesting or rendering provider must provide the following information to request authorization (regardless of the method utilized):

- Member's name, date of birth and ID number
- Provider's NPI number, taxonomy code, name, and telephone number
- Facility name if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure

The procedure code(s). Note: If changes to the planned and authorized procedure(s) it is recommended that within 72 hours or prior to the time the claim is submitted that you phone the Ovation Authorization Department at 866-549-4199, or if any of the following are updated:

- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure
- Discharge plans

Failure to update as above, may result in claim denials.

Pharmacy

Ovation members pharmacy benefits are covered by Drexi. Information on Drexi benefits and contacts can be found in the Ovation Summary of Benefits on our website https://www.ovation.health

ENCOUNTERS AND CLAIMS

Encounter

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or retained or the services, they provided our members. For example, if you are the PCP for an Ovation Member and receive a monthly retainer amount for services, you can file an encounter (also referred to as a "proxy claim") on a CMS 1500, UB 04, or other standardized claim form for each service provided. Since you will have received a pre-payment in the form of retainer, the encounter or "proxy claim" is paid at zero-dollar amounts. It is not mandatory that your office submits encounter data.

Claim

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500, UB 04, or other standardized claim form. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP. Providers are required to submit either an encounter or a claim for each service that you render to an Ovation Member.

Claim Submission

In general, Ovation follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Ovation is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment if not submitted correctly. Claims will be rejected or denied if not submitted correctly.

Verification Procedures

All claims filed with Ovation are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form (02/12), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our Secure Provider Portal, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
    - Date of Service

- Provider Type and/or provider specialty billing
- Age and/or sex for the date of service billed
- Bill type
- All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
    - F2 – International Unit
    - GR – Gram
    - ME – Milligram
    - ML – Milliliter
    - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
- For a CMS 1500 Claim Form, this criterion looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
- All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
    - N – No
    - U – Unknown
    - W – Not Applicable
    - Y – Yes
- Member is eligible for services under Ovation during the time period in which services were provided.
- Services were provided by a participating provider, or if provided by an "out of network" provider authorization has been received to provide services to the eligible member. (Excludes services by an "out of network" provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization has been given for services that require prior authorization by Ovation.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in the health plan's systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.

Non-Clean Claim Definition

Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Upfront Rejections vs Denials

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in the Appendix of this Manual. A list of common upfront rejections can be located in Appendix I of this Manual. Upfront rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed edits and is entered into the system, however, has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

Timely Filing

Participating providers must submit first time claims within 180 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

Who Can File Claims?

All providers who have rendered services for Ovation members can file claims. It is important that providers ensure Ovation has accurate and complete billing information on file. Please confirm with the Provider Services department or Provider Partnership Manager that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)
- Tax Identification Number (TIN)
- Taxonomy code (This is a REQUIRED field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address (as noted on current W-9 form)

We recommend that providers notify Ovation 60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Electronic Claims Submission

Providers are encouraged to submit clean claims and encounter data electronically. Ovation can receive an ANSI X12N 5010 837 professional, institutional transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Ovation has partnered with, contact:

Ovation Health
by phone at **1-866-549-4199**
by email at: **claims@ovation-health.com**

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Ovation has the ability to receive coordination of benefits (COB or secondary) claims electronically. Ovation follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

Ovation's Payer ID is 20510

Specific Data Record Requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Ovation, all EDI claims must first be forwarded to one of Ovation's clearinghouses. This can be completed via a direct submission to a clearinghouse, or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Ovation. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ovation and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Ovation by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily. Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Ovation.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Ovation must first pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Ovation. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in Timely Filing section of this Manual. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI Support at **1-866-549-4199**, or via email at **claims@ovation-health.com** If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

Corrected EDI Claims

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
- Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Exclusions

- The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:
- Claim records requiring supportive documentation or attachments (i.e. consent forms). (Note: COB claims can be filed electronically)
- Medical records to support billing miscellaneous codes
- Claims for services that are reimbursed based on purchase price i.e., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review (i.e. complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity (i.e., oxygen, motorized wheelchairs).

Paper Claim Submission

The mailing address for first time claims, corrected claims, and requests for reconsideration:

Ovation Health
Attn: Claims
22001 Northpark Drive, Suite 200
Kingwood, TX 77339

Ovation encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available in the Appendix section of this Manual. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claim's office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

Ovation only accepts the original red and white CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will be upfront rejected and returned to the provider. This includes black and white forms, as well as form with handwriting. Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ovation does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact the Ovation Claims department.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 unless a qualifying circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by Ovation or the Federal and/or State regulatory body.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID Card or information
    - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered
    - The provider has not filed a claim for this member prior to the filing of the claim under review

Corrected Claims

All requests for corrected claims must be received within 180 calendar days from the date of explanation of payment or denial is issued. Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a Clearinghouse
- Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
- Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
- Submit a corrected paper claim to:

Ovation Health
Attn: Claims
22001 Northpark Drive, Suite 200
Kingwood TX 77339

- The original claim number must be typed in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. All requests for reconsideration must be received within 90 calendar days from the date of explanation of payment or denial is issued. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit or authorization denial, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. **Form** - Providers may utilize the Request for Reconsideration form found on our website (preferred method).
2. **Phone call to Claims Department** - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate.
3. **Written Letter** - Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information which includes, at a minimum, the member's name, member's ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form. The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form.

Requests for reconsideration and any applicable attachments must be mailed to:

Ovation Health
Attn: Claims
22001 Northpark Drive, Suite 200
Kingwood, TX 77339

Claim Dispute

A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

A claim dispute must be submitted on a claim dispute form found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute form may be mailed to:

Ovation Health
Attn: Claim Disputes
22001 Northpark Drive, Suite 200
Kingwood, TX 77339

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Ovation shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status in accordance with law and regulation.

Coding Of Claims/ Billing Codes

Ovation requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of services
- Code inappropriate for the age or sex of the member
- Diagnosis code missing the 4th and 5th digit as appropriate
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Ovation.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother, and their newborn. Newborns are covered under the mother's policy for thirty (30) days from birth.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code / modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact Ovation Claims Department.

Code Editing

Ovation does not Re-Code or Edit CPT Codes on claims. An invalid CPT is rejected as a non-clean claim, with instructions on correct codes.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Ovation will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

Failure to obtain authorization

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied by Ovation.

No Balance Billing

Providers may not seek payment from Ovation members for the difference between billed charges and the contracted rate paid by Ovation

Non-Covered Services

Contracted providers may only bill Ovation Members for non-covered services if:

- A request for prior authorization was denied by the plan and the member received a written Notice of Denial of Medical Coverage in advance of receiving the service; or
- The member's Evidence of Coverage clearly states the item or service is never covered by the plan

MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights of members as set forth below.

Member Rights

1. To participate with providers in making decisions about their health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options
2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly
3. To receive the benefits for which the member has coverage
4. To be treated with respect and dignity
5. To privacy of their personal health information, consistent with state and federal laws, and Ovation policies
6. To receive information or make recommendations, including changes, about Ovation's organization and services, the Ovation network of providers, and member rights and responsibilities
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care physician about what might be wrong (to the level known), treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger
8. To make recommendations regarding the Ovation member's rights, responsibilities and policies
9. To voice complaints or appeals about: Ovation, any benefit or coverage decisions Ovation makes, Ovation coverage, or the care provided
10. To participate with practitioners in making decisions about their care and the right to refuse treatment for any condition, illness, or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences
11. To see their medical records
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ovation rules and guidelines. Ovation will notify members before the effective date of the modifications. Such notices shall include the following:
    - Any changes in clinical review criteria
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes

13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin or religion
16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week
17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability
18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision.
19. To select a primary care physician within the network. The member has the right to change their primary care physician or request information on network providers close to their home or work.
20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care physician
21. To have access to an interpreter when the member does not speak or understand the language of the area.
22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
    - Living Will
    - Health Care Power of Attorney
    - "Do Not Resuscitate" Orders

Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

Member Responsibilities

1. To read their Ovation contract in its entirety
2. To treat all health care professionals and staff with courtesy and respect
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider, so they understand the care they are receiving
4. To review and understand the information they receive about Ovation. The member needs to know the proper use of covered services

5. To show their I.D. card and keep scheduled appointments with their provider, and call the provider's office during office hours whenever possible if the member has a delay or cancellation
6. To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Ovation Member Services Department
7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it
8. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible
9. To supply, to the extent possible, information that Ovation and/or their providers need in order to provide care
10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers
11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision
12. To follow all health benefit plan guidelines, provisions, policies, and procedures
13. To use any emergency room only when they think they have a medical emergency. For all other care, the member should call their primary care physician
14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Ovation coverage, the member must provide this information to Ovation
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Ovation members, and other healthcare workers with dignity and respect
2. To receive accurate and complete information and medical histories for members' care
3. To have their patients, who are Ovation members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
4. To expect other network providers to act as partners in members' treatment plans
5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times
6. To make a complaint or file an appeal against Ovation and/or a member
7. To file a grievance on behalf of a member, with the member's consent
8. To have access to information about Ovation quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
9. To contact Provider Services with any questions, comments, or problems
10. To collaborate with other health care professionals who are involved in the care of members
11. To not be excluded, penalized, or terminated from participating with Ovation for having developed or accumulated a substantial number of patients in Ovation with high-cost medical conditions
12. To collect member cost shares at the time of the service

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
    - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
2. To treat members with fairness, dignity, and respect
3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service

6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
7. To allow members to request restriction on the use and disclosure of their personal health information
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
12. To respect members' advance directives and include these documents in their medical record
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately
15. To follow all state and federal laws and regulations related to patient care and rights To participate in Ovation data collection initiatives, such as HEDIS and other contractual or regulatory programs
16. To review clinical practice guidelines distributed by Ovation
17. To comply with the Ovation Medical Management program as outlined herein
18. To disclose overpayments or improper payments to Ovation
19. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
20. To obtain and report to Ovation information regarding other insurance coverage the member has or may have
21. To give Ovation timely, written notice if provider is leaving/closing a practice
22. To contact Ovation to verify member eligibility and benefits, if appropriate
23. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
24. To provide members with information regarding office location, hours of operation, accessibility, and translation services
25. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
26. To provide hours of operation to Ovation members which are no less than those offered to other Medicare patients

MEMBER GRIEVANCES AND APPEALS

Grievances

Members must follow the grievance process as listed below when a member is dissatisfied with the manner in which Ovation, or a delegated entity provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services
- Setting of health services
- Procedures
- Items
- Standards for delivery of care

Members or their representative may submit a grievance verbally, in writing, via phone, mail, facsimile, electronic mail or in person within 60 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member's case requires, based on health status, but no later than 24 hours for expedited grievances and 30 calendar days for standard grievances. Extensions of up to 14 calendar days can be granted for standard grievances if the enrollee requests the extension or if Ovation justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Ovation. Appeals must be submitted to the address below within 60 days of the decision. Expedited re-determinations/reconsiderations will be made on medical care or drug coverage not yet received if standard deadlines could cause serious harm to the member's health.

Member Grievance and Appeals Addresses

Written grievances and appeals must be mailed, emailed, or faxed to:

Ovation Health
ATTN: Grievances and Appeals
22001 Northpark Drive, Suite 200
Kingwood, TX 77339

membership@ovation-health.com

Fax: 866-234-8707

PROVIDER COMPLAINT AND APPEALS PROCESS

Ovation Complaint

A Complaint is a verbal or written expression by a provider which indicates dissatisfaction with Ovation's policies, procedure, or any aspect of Ovation's functions. Ovation logs and tracks all complaints/grievances whether received verbally or in writing. A provider has thirty (30) calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint. After a complete review of the complaint/grievance, Ovation shall provide a written notice to the provider within thirty (30) calendar days from the received date of Ovation's decision. If the complaint is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Ovation
ATTN: Provider's Complaint
22001 Northpark Drive, Suite 200
Kingwood, TX 77339

Authorization and Coverage Appeals

An Appeal is the mechanism which allows providers the right to appeal actions of Ovation such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Ovation. A provider has thirty (30) calendar days from Ovation's notice of action to file the appeal. Ovation shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Ovation shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed thirty (30) calendar days from the date Ovation receives the appeal. Ovation may extend the time frame for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or Ovation demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Ovation shall provide written notice to the member for the delay.

Expedited appeals may be filed with Ovation if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the time frame for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal. Ovation may extend this time frame by up to an additional fourteen (14) calendar days if the member requests the extension or if Ovation provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.