KOVA Healthcare, Inc.
Doctor focused patient centered.

7061 N. WHITNEY SUITE 102 FRESNO, CA 93720

Provider Manual

KOVA Healthcare, Inc.

Updated September 2025

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Introduction

Welcome to the KOVA Healthcare, Inc. Provider Network. Medical providers are key to the successful delivery of healthcare for participants accessing the KOVA Provider Network. We encourage your active participation in the KOVA network and invite your inquiries on operational matters.

Vision/Mission

KOVA 's vision is to be the leading KOVA Medicare Advantage s IPA in our service areas, and preserve the health, independence, and quality of life of Medicare beneficiaries in the communities we serve.

Our mission is to improve the health of our members by providing the highest quality health and human services through an innovative, world-class, member-focused delivery system, Doctor Focused…Patient Centered.

Purpose of this Manual

This Manual will acquaint you and your staff with the administration of KOVA 's KOVA Medicare Advantage s network. The manual explains KOVA 's administrative policies and procedures as well as providing information on the health plan's we administer.

We suggest that this manual be kept available for easy reference. This manual is frequently updated, and the most current version is available on our web site: www.kovahealth.com.

Service Area

KOVA's network to services the following counties within California:

- Fresno, California
- Tulare, California
- Kern, California
- Madera, California
- Kings, California

Compliance

KOVA has a comprehensive ethics-based Compliance Program that reflects how fundamental components of our business operations are conducted. KOVA recognizes that its employees and Provider affiliates are the keys to providing quality healthcare services and is committed to managing its business operations in an ethical manner, in accordance with contractual obligations, and consistent with all applicable statutes, regulations and rules.

An overview of the KOVA Compliance Program can be found in our policies and procedures. It applies to all KOVA personnel, its Board members, contractors, suppliers, and participating Providers.

To report a compliance issue, please call the KOVA Compliance Department at 559-207-3198.

Fraud, Waste & Abuse

KOVA is dedicated to the detection, prevention, and correction of potential healthcare Fraud, Waste, and Abuse ("FWA"). Our FWA Program was developed in accordance with the following Federal and State statutes, regulations, and guidelines:

- Applicable State laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

The FWA Program has been developed to comply with all standards set forth by the regulations and laws of the United States Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS). The

FWA Program and the FWA Program Description are reviewed periodically by the KOVA Quality Management and Compliance team, with revisions made as needed.

Definitions

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

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

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically necessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other facts.

Common examples of Medicare fraud include billing for services that were not provided, billing of unnecessary services, misrepresenting dates of service, or providers of service, and paying kickbacks for patient referrals.

Examples of Fraud, Waste, and Abuse

Please report fraud, waste and abuse if you see it. There are many examples of fraud, waste and abuse. Some examples are below.

- A provider charges KOVA for services it did not provide.
- A provider offers KOVA members money or kickbacks to use their services.
- A KOVA member lends an ID card to someone else.
- A KOVA member sells drugs they were prescribed or forges a prescription.
- A provider performs medically unnecessary services to receive payment from KOVA.

FWA Reporting

KOVA accommodates anonymous, confidential, and private, good faith reporting of instances of suspected FWA. KOVA maintains confidential reporting mechanisms that individuals can use to report suspected FWA. KOVA 's FWA Hotline is available 24/7.

To report an issue, please call 559-207-3198, e-mail QualityImprovement@kovahealth.com, or fax to 559-207-3198.

HIPAA

Health Insurance Portability and Accountability Act (HIPAA) The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities such as health plans, healthcare clearinghouses and most healthcare Providers, including pharmacies, to safeguard the privacy of patient information.

Covered entities are required to conduct HIPAA Privacy training on an annual basis and to ensure ongoing organizational compliance with the regulations. A major goal of the Privacy Rule is to ensure that an individual's personal health information is properly protected while still allowing the flow of health information needed to provide and promote high-quality healthcare, as well as to protect the public's health and well-being. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of Protected Health Information (PHI).
The following are examples of appropriate safeguards that organizations/Providers should take to protect the security and privacy of PHI:

- Ensure that data files are not saved on public or private computers while accessing corporate email through the Internet
- Ensure that electronic systems for beneficiary mailings are properly programmed to prevent documents containing Personal Identifiable information (PII) from being sent to the wrong beneficiaries
- Ensure that PHI data on all portable devices are encrypted
- Implement security measures to restrict access to PHI based on an individual's need to access the data
- Perform an internal risk assessment or engage an industry-recognized security expert to conduct an external risk assessment of the organization to identify and address security vulnerabilities
- Shredding documents containing PHI before discarding them
- Securing medical records with lock and key or passcode
- Limiting access to keys and passcodes
- Locking computer screens when away from your desk/workstation
- Refraining from discussing Member information outside the workplace, lunchrooms, elevators, lobby, etc.

Please refer to the Compliance Program for additional information.

Health Care Delivery System

KOVA is a Medicare Advantage IPA that provides coordinated care to Medicare beneficiaries who selected our KOVA as their managed care advantage partner and selective health plan. A common feature of our plans is working closely with our participating healthcare providers in performing utilization review, case management, and population health management programs.

Participating Providers

Participating Providers are, partner Health Plans, primary care physicians, specialist physicians, ancillary providers, hospitals, and facilities who are contracted with KOVA. KOVA works with Participating Providers on contract inquires and compliance issues (ensuring that KOVA maintains adequate provider networks and accurate/current provider directories). Participating Providers are required to follow the administrative procedures delineated in the next section and to notify KOVA of requests for provider additions, terminations, location, location information changes, and panel closures.

Contact Information

A current provider directory, pharmacy directory, and benefit options are available at www.kovahealth.com

KOVA has a web portal that allows you to:

- verify member eligibility
- view plan benefit information
- submit authorizations
- check claim status

Go to www.kovahealth.com/provider-resources and register for a portal account. You can create your own user ID and password. If you have questions, contact Provider Services at JennaL@KOVAHealth.com or 559-207-3198.

Provider Call Center

For benefits, claims payment issues, multiple claims on the system, and coordination of benefits call:

KOVA Healthcare, Inc. at 559-207-3198

Provider Services Department

For: Contracting, credentialing, provider education, quality of care issues, Federal Tax Identification Number changes, fee schedules, contract termination procedures, and provider mailings.

- Email at JennaL@KOVAHealth.com
- Log into Web Portal at www.kovahealth.com/provider-resources
- Fax: 559-207-3901

Medical Management Department

For: Certification for hospital admissions, appropriate outpatient services, inpatient & outpatient mental health services and referral authorizations.

- Log into Web Portal at www.kovahealth.com/provider-resources
- Call 559-207-3198

If you are affiliated with a delegated medical group, please refer to your group's Medical Management Department.

Provider Disputes

KOVA participants have the right to initiate a dispute pertaining to issues of professional competency and/or conduct, quality of care, patient safety, and administrative issues. All these disputes are subject to the participating network agreement between the contracted provider and KOVA.

Providers can send all written disputes to:

KOVA Healthcare, Inc. Attn: Provider Dispute
7061 N. Whitney Ave, Suite 102 Fresno CA. 93720

Medicare Advantage Plan Benefits

KOVA is open to all Medicare beneficiaries who meet all of the additional applicable eligibility requirements for membership (including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefit); qualify for Medicare parts A and B; have voluntarily elected to enroll; and whose enrollment in KOVA has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

KOVA provides comprehensive, coordinated medical services to members on a prepaid basis through established Provider networks. KOVA Medicare Advantage plans members must choose a Primary Care Physician (PCP) or Clinic and have all their care coordinated through this Provider. This includes referrals to other specialty providers as needed.

Medicare Advantage plans are regulated by the Centers for Medicare & Medicaid Services (CMS), the same Federal agency that administers Medicare, and by the California Department of Managed Health Care (DMHC).

KOVA Benefit Summary

KOVA offers its members benefits such as:

- Inpatient Acute Hospital, Skilled Nursing and Psychiatric Care
- Home Healthcare
- Doctor Office Visits
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Healthcare
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Ambulance Services
- Emergency Medical Services
- Outpatient Rehabilitation Services
- Durable Medical Equipment (DME)
- Prosthetic Devices
- Part D Prescription Drugs
- Hearing Aids
- Preventive Exams
- Chronic Care Needs and Plans
- Acupuncture
- Out-of-Area Urgent and Emergent Medical Services
- Worldwide Emergency Travel Care
- Medical Nutrition Therapy
- Preventive and Comprehensive Dental Care
- Vision Services
- Transportation Services
- Telehealth services (outpatient medical & behavioral health)
- Fitness Membership
- OTC Drugs

Supplemental Services

KOVA has implemented programs to enhance its services for KOVA Medicare Advantage members. These Supplemental Services are designed to provide members with additional services not usually covered by traditional Medicare or other health plans. Because benefits may change each year or may have some restrictions and/or limitations, please refer members to their annual Summary of Benefits and Evidence of Coverage documents, which are available on the KOVA website at www.kovahealth.com.

Supplemental Services include:

Acupuncture

KOVA members may self-refer to a contracted Acupuncturist without having to obtain authorization from their PCP or KOVA. For 2022, 30 visits per calendar year are covered under this benefit. Please direct any questions to the KOVA's Member Services Department at 559-207-3198.

Comprehensive Dental

KOVA offers coverage for dental services. For 2025, all members have access to dental services as part of their KOVA Benefits. Questions relating to dental services can be answered by calling KOVA's Member Services Department at 559-207-3198.

Comprehensive Vision and Eyewear

KOVA members have coverage for routine vision exams and eyewear through their contracted Medicare Advantage Plans. Questions relating to comprehensive vision & eyewear can be answered by calling KOVA's Member Services Department at 559-207-3198.

Hearing Aids

Hearing aids are not a Medicare-covered benefit. However, KOVA benefits offer a supplemental benefit through their contracted Health Plans. Please direct any questions about hearing aids benefits to the KOVA's Member Services Department at 559-207-3198.

Transportation to Medical Appointments

KOVA's health plans have partnered with medical transportation to provide transportation for medically necessary services. The purpose of transportation service is to:

1) assist Members in obtaining timely evaluation and treatment as recommended by their physicians; and
2) help ensure that a member's healthcare is not compromised by a lack of transportation

Fitness Program Membership

KOVA's members have fitness benefits through their contracted Medicare Advantage Plans. Please direct any questions to the KOVA Customer Service Department at 559-207-3198.

Culturally and Linguistically Appropriate Services

KOVA recognizes that providing culturally and linguistically appropriate services is a crucial component to ensuring member access to quality healthcare services. As such, KOVA has a policy that when our enrolled membership reaches 5% of the benefit plan population, member documents are translated into the spoken language. Currently, KOVA offers member information in English and Spanish. However, if your member cultural population is primarily other than English or Spanish, please contact our Member Services for material in your member preferred language.

To help ensure culturally and linguistically appropriate services, KOVA:

- Recruits and employs qualified bilingual and bicultural staff who have the knowledge and experience of working within the culture.
- Provides cultural diversity and sensitivity training to its staff and Provider office staff to promote understanding of cultural differences among ethnic communities.
- Provides access to interpreter services at key points of contact for all members, including those who may be deaf or hard of hearing. Program information is available and understandable to any non-English speaking member. This is accomplished using a 24-hour interpretation service for phone calls and a contract for face-to-face interpreter services to provide interpretation on a scheduled basis.
- Provides written materials in languages most familiar to KOVA members when any given population segment is equal to or greater than 5% of the total member population. Member educational materials are developed at appropriate member literacy level and quantity for the given language.

- Conducts regular informational presentations and targeted outreach for different ethnic communities at community-based organizations to ensure that information on KOVA programs and benefits are dispersed to a wide range of members.
- Works closely with community and faith-based organizations across each county to ensure our members have a wide range of culturally and linguistically appropriate services available to them.
- Requires that KOVA members have direct access to contracted specialist services whenever the member's PCP in collaboration with the appropriate specialist and network medical director determine that the medical or service complexity warrants ongoing care by a specialist over a prolonged period. Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) and complex cancer are examples of conditions that may require specialized medical care over a prolonged period.
- Assigns a Case Manager to members who are identified as high risk through the initial risk assessment or subsequently through a variety of avenues, such as inpatient, emergency room or outpatient access, to assist in ensuring that care is provided in a timely, efficient and cost-effective manner.

For More Information

For information about any of KOVA 's Benefits and/or Supplemental Services, please call KOVA at 559-207-3198. If KOVA members have questions about these services, please have them call our Customer Service Department at 559-207-3198.

Administrative Procedures

Overview

This section of this manual details KOVA's administrative procedures. The information provided describes provider network accuracy, claims processing, member billing, KOVA's responsibilities and provider obligations.

Confidentiality

KOVA employees, in accordance with HIPAA, HITECH and other applicable laws, will maintain the privacy and confidentiality of its providers and members. KOVA acknowledges the importance of maintaining the privacy and confidentiality of provider information, peer review material, facility, and member information and documents associated with carrying out healthcare activities (verbal and/or written) and therefore, they will be kept confidential and comply with state and federal laws and regulations.

KOVA and KOVA providers must comply with all State and Federal laws concerning confidentiality of PHI (Protected Health Information) about members. Providers must have policies and procedures in place for use and disclosure of PHI that comply with applicable laws.

Non-discrimination

Providers must have policies and procedures in place to ensure that covered services are provided to members regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or national origin, cultural or educational background, economic or health status, and/or source of payment for care. Providers must also comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information nondiscrimination Act of 2008.

Billing Members

Balance Billing

Providers shall accept payment from KOVA for Covered Services provided to KOVA Members in accordance with the reimbursement terms outlined in their respective Participating Provider Agreement.

Payment from KOVA for Covered Services constitutes payment in full, with the exception of applicable Member share of cost.

For Covered Services, Providers shall not balance bill Members any amount more than the contracted amount in their respective Participating Provider Agreement. An adjustment in payment because of KOVA's claims policies and/or procedures does not indicate that the service provided is a Non-Covered Service, and Members are to be held harmless for Covered Services.

Providers may not bill Members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered Services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the Provider fails to notify KOVA of a service that required Prior Authorization
- Covered Services that were not Medically Necessary, in the judgment of KOVA, unless prior to rendering the service the Provider obtains the Member's informed written consent and the Member receives information that he or she will be financially responsible for the specific services
- Any other instance in which payment for a Covered Service is denied or reduced, in accordance with the Agreement or this Manual, as a result of a Provider not complying with the requirements of the Agreement or this Manual.

Member Expenses and Maximum Out-of-Pocket

The Provider is responsible for collecting Member Expenses. Providers are not to bill Members for missed appointments, administrative fees, or other similar type fees.

If a Provider collects Member Expenses determined by KOVA to exceed the correct amount of Member Expenses, the Provider must promptly reimburse the Member the excess amount. The Provider may determine an excess amount by referring to the Explanation of Payment (EOP). For MA Benefit Plans, Member Expenses are limited by a maximum out-of-pocket amount.

**Federal law bars Medicare providers from collecting Medicare Part A and Medicare 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. (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997). Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. See 42 CFR §422.504(g)(1)(iii). For more information about dual eligible categories and benefits, please visit: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs*

Members may not be billed for services provided that are denied due to CCI edits** or the provider's failure to file a timely claim, submit a complete claim, respond to requested information, or comply with policy and procedures as required by the provider's agreement with KOVA.

Members can be billed for non-covered services but must be made aware of their financial obligation prior to the service being rendered.

**The National Correct Coding Initiative (NCCI, or more commonly, CCI) is an automated edit system to control specific Current Procedural Terminology (CPT) code pairs that can be reported on the same day. The purpose of the CCI edits is to prevent improper payment when incorrect code combinations are reported.

Provider Network Accuracy

Participating Providers are required to notify KOVA of requests for provider additions, terminations, demographic changes, and panel closures. If the change is an addition of a new Participating Provider, then the notification should be emailed to AngelaS@kovahealth.com.

CMS requires prompt outreach to Members when a provider is terminated. KOVA requests the Participating Provider send notification as they become aware of an upcoming termination, informing KOVA of the estimated termination date. In order to fully comply with CMS requirements, KOVA requires at *least ninety (90)* calendar days' prior written notice of the termination of any of its Participating Providers.

In the event a Participating Provider is terminated with less than ninety (90) days' notice, the Participating Provider must give written notice within five (5) business days of becoming aware of the termination. When a PCP is terminated KOVA also requests:

- Default PCP to whom KOVA should transfer the Members;
- Termination reason (e.g., Medicare Opt-Out, deceased); and
- Termination date

Claims Submission

Payment for services rendered is subject to verification that the member was enrolled in KOVA at the time the service was provided and to the provider's compliance with the KOVA Clinical Services and prior authorization policies at the time of service.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in KOVA. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with KOVA after the date of service. Therefore, verification of eligibility is not a guarantee of payment by KOVA.

Taxonomy

Providers are encouraged to submit claims with the correct taxonomy code consistent with Provider's specialty and services being rendered to increase appropriate adjudication. KOVA may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect or omitted; in such cases, Provider must not bill or accept payment from the Member for the amount denied or reduced by KOVA

National Drug Codes

KOVA follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit National Drug Codes as required by CMS.

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE), or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. If a claim is rejected for lack of compliance with KOVA's claim and encounter submission requirements, the rejected claim should be resubmitted within timely filing limits based on the date of service.

Providers using electronic submission shall submit Clean Claims to KOVA or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/UB-04 (or their successors), as applicable.

Claims shall include the Provider's NPI, Tax ID and the valid taxonomy code that most accurately describes the services reported on the claim.

The Provider acknowledges and agrees that no reimbursement or compensation is due for a Covered Service, and no claim is complete for a Covered Service, unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim.

The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider with the exception of Member expenses or Non-Covered Services, as delineated above in Member Expenses and Maximum Out of Pocket above. This includes cases in which payment is denied or reduced as a result of Provider's failure to follow the requirements set forth in this Manual.

Paper Claims Submissions

Providers are encouraged to submit claims to KOVA electronically, through our provider portal. If the provider does not have the capability to bill electronically, paper submission or direct data entry are available.

All paper claims must include the National Provider Identifier (NPI), as applicable and be submitted on (UB-04 or CMS-1500, or their successors). Paper claims must be typed and not handwritten due to legibility concerns. Any missing, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly.

Do not use red ink, mini-fonts, script, italics, or stylized fonts.

Paper Claims submitted by mail should be addressed to:

KOVA Healthcare, Inc.
PO Box 4367
Orange, Ca. 92865

Hospice Claims

When a member elects hospice (provided by Medicare Hospice Providers), claims should be submitted to the hospice provider for services related to the terminal diagnosis. A KOVA Medicare Advantage enrollee who elects hospice care but chooses not to dis-enroll from the plan, is entitled to continue to receive through the plan any KOVA Medicare

Advantage benefits other than those that are the responsibility of the hospice. The member is responsible for cost-sharing as identified by KOVA, as long as the member remains enrolled in KOVA's KOVA Medicare Advantage.

KOVA is responsible for any supplemental benefits outlined in the member's plan as long as it is authorized by the treating physician, the member utilizes a plan provider and remains enrolled in KOVA's plan. Such services should be billed to KOVA following the Claims Submission guidelines identified in this manual.

Claims for Prescription Drugs

Immunizations/vaccines covered under Medicare Part B services will be considered and outlines in your Provider Contract.

Medicare Part B Prescription Drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan.

Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit ®)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Electronic Claims Submission

Claims may be submitted electronically through the clearinghouse Office Ally. Claims submitted electronically receive status reports indicating the claims are accepted, rejected and/or pending.

Claims submitted electronically must include:

- The Payer ID Number on each claim.
- A complete KOVA Member ID Number.
- A National Provider Identifier (NPI).

Additional software vendors and clearinghouses may transmit claims. Providers should verify this prior to claim submission to ensure timely receipt and accurate processing of claims.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as KOVA, as well as Providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using HIPAA designated content and format.

To promote consistency and efficiency for all claims and encounter submissions to KOVA, it is KOVA's policy that these requirements apply to all paper and DDE transactions.

All Providers must submit HIPAA compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at www.cms.gov, and the ICD-10 Lookup Tool at www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx for specific codes.

Clean Claim Submission

A clean claim is a claim that has all fields required by CMS for both 1500 and UB 04 claim forms completed. A claim will not be considered clean if it is missing any of the required fields or attachments required to adjudicate the claim.

To be considered "clean," a claim must meet the following criteria:

- HIPAA compliant
- EDI compliant format
- Have all required fields completed
    - National provider identifier (NPI) numbers
        - Paper Claims: Box/field 24j displays the rendering provider (Individual NPI); box/field 33a displays the billing provider location (Group NPI)
        - Electronic Transactions: NM1 *85 segment contains the Group NPI; MN1 *82 segment contains the Individual NPI
    - Provider's name and NPI
    - Provider's federal tax identification number (TIN)
    - Vendor name and address
    - Member's full name, date of birth, and ID number
    - Date of service
    - Valid diagnosis code(s)
    - Valid procedure codes(s) and modifier code(s), if applicable
    - Valid place of service
    - Charge information and units
    - National Drug Codes, when applicable
- Not require further investigation by the plan/IPA
- Be received within the timely filing period (varies depending on group or plan) please call KOVA Member Services, for group and plan specific instructions.
- **KOVA timely filing limit is threw hundred sixty five (365) days from the date of service.**
- Have all information necessary to adjudicate a claim including any necessary supporting documentation (primary carrier explanation of benefits (EOB), medical records, etc.)

If the information is incomplete or incorrect the claim will not be considered "clean", and we will be required to return the claim with a request for additional information.

In accordance with CMS guidance, KOVA will pay complete claims within *30 calendar days*. Interest is payable if it is calculated to be $1.00 or more. Interest is paid based on the rate set by the Federal Bureau of the Fiscal Service and can be located at fiscal.treasury.gov/prompt-payment/rates.html.

Resubmitting Claims

Prior to resubmitting a claim, check the claim's status through the KOVA website or call the KOVA Claims Department. The provider should only resubmit the claim if one of the following is not received within 30 calendar days:

- Payment
- Remittance advice
- Letter requesting additional information
- Any other form of notification from KOVA regarding the status of a submitted claim

Submitting a Corrected Claim

Corrected and/or voided claims are subject to timely claims submission (i.e., timely filing) guidelines. How to submit a corrected or voided claim electronically:

- Loop 2300 Segment CLM composite element CLM05-3 should be '7' or '8' – indicating to replace '7' or void '8'
- Loop 2300 Segment REF element REF01 should be 'F8' indicating the following number is the control number assigned to the original bill (original claim reference number)
- Loop 2300 Segment REF element REF02 should be 'the original claim number' – the control number assigned to the original bill (original claim reference number for the claim you are intended to replace.)
- Example: REF*F8*KOVA Claim number

These codes are not intended for use for original claim submission or rejected claims.

To submit a corrected or voided claim via paper:

- For Institutional claims, the Provider must include KOVA's original claim number or claim number the Provider is requesting be corrected/voided and bill the frequency code per industry standards.
  - On the UB04, Box 4 – Type of Bill third character must represent the "Frequency Code"
  - Box 64 – Document Control Number is where you place the original claim number you are requesting be corrected/voided
- For Professional claims, the Provider must include KOVA 's original claim number or the claim number the Provider is requesting be corrected/voided and bill the frequency code per industry standards.
  - On the CMS-1500, Box 22 – Resubmission Code must indicate a "7" or "8"
  - Part two of Box 22 – Original Ref. No. is where you place the original claim number you are requesting be corrected/voided

Any missing, incomplete, or invalid information in any field may cause the claim to be rejected.

Please note: If "corrected claim" or "voided claim" is handwritten, stamped, or typed on the claim form without the appropriate Frequency Code "7" or "8" on either Institutional or Professional claims along with the reference number as indicated above, the claim will be considered an original first-time claim submission.

Payment Listing—Remittance Advice

The KOVA Remittance Advice form explains the payment or denial on each claim that was submitted by the provider and processed by KOVA.

Timely Claims Submission

Unless prohibited by federal law or CMS, KOVA may deny payment of any claim that fails to meet KOVA's submission requirements for Clean Claims or failure to timely submit a Clean Claim to KOVA. A Provider whose claim is denied as described in this paragraph must not bill or seek payment from a Member for the services in question.

The following items can be accepted as proof a Clean Claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted
- A Provider's electronic submission sheet that contains all the following identifiers:
  - Patient name
  - Provider name
  - Date of service to match Explanation of Benefits (EOB)/claim(s) in question
  - Prior submission bill dates

Encounter Data

Overview

KOVA requires all delegated vendors, delegated Providers, and capitated and FFS Providers, such as medical groups, to submit timely encounter data to KOVA, even if they are reimbursed through a capitated arrangement. This section is intended to give Providers necessary information to allow them to submit encounter data to KOVA. If encounter data do not meet the requirements set forth in KOVA 's government contracts for timeliness of submission, completeness or accuracy, federal and state agencies (e.g., CMS) can impose significant financial sanctions on KOVA which KOVA will pass down to contracted entities.

Timely and Complete Encounters Submission

Unless otherwise stated in the Agreement, vendors and Providers must submit complete and accurate encounter files to KOVA as follows:

- On a monthly basis in a standard encounter reporting format e.g., HIPAA 837 claim format;
- Capitated entities will submit within 10 calendar days after the end of month in which service was rendered;
- The above applies to both corrected claims (error correction encounters) and capitation-priced encounters.

Accurate Encounters Submission

All encounter transactions submitted via DDE or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines per the federal requirements. SNIP levels 1 through 3 shall be maintained.

Once KOVA receives a Provider's encounters, the encounters are loaded into KOVA's encounters system and processed. The encounters are subjected to a series of SNIP Edits to ensure that the encounter has all the required information, and that the information is accurate. Vendors are required to comply with any additional encounters validations as defined by CMS.

Encounters Submission Methods Delegated Providers may submit encounters using the following methods: electronically, through KOVA 's contracted clearinghouse, SDS Provider Portal via DDE or via a paper claim.

Encounters Data Types

There are four encounter types for which delegated vendors and Providers are required to submit encounter records to KOVA. Encounter records must be submitted using the HIPAA standard transactions for the appropriate service type. The four encounter types are:

- Dental – 837D format
- Professional – 837P format
- Institutional – 837I format
- Pharmacy – NCPDP format

Claims Payment Disputes

The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to KOVA in writing *within 60 calendar days* of the date of the last action on the claim as set forth in the EOP. When submitting a dispute, the Provider must provide the following information:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN/NPI
- Total billed charges
- The Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

Submit your dispute letter to:

KOVA Healthcare, Inc.
PO Box 4367
Orange, CA 92865

Coordination of Benefits (COB)

Coordination of benefits is a provision in an insurance plan that guarantees each responsible insurer (when a patient is covered under more than one plan) pays only its own portion of claims and prevents double recovery of claims.

Coordination of benefits also designates the order in which multiple carriers pay benefits. The following is a list of definitions used when coordinating benefits. Note that self-funded employer sponsored plans may have specific rules for their member benefit plan. The listed definitions are standard industry guidelines.

Medicaid

- The Medicaid Medical Assistance Program (Title XIX of the Social Security Act) provides matching funds to states to help provide medical care and services for the lower income persons. Medicaid is the payer of last resort. Once Medicaid has been billed, the provider must accept the reimbursement rate as payment in full and cannot bill the recipient or an insurer for the balance.

Medicare

- Medicare is the Federal Health Insurance Program (Title XVIII of the Social Security Act) for people aged 65 years and older and those with certain disabilities. Medicare is composed of two parts: Part A (Hospital Inpatient Insurance) and part B (Hospital Outpatient and Medical Insurance).

Primary

- Primary means the member's first source of insurance coverage is his/her health plan. Primary coverage is determined by the KOVA's Authorization and/or Member Services Department.

Secondary

- Secondary means the member has other health insurance, which is considered before KOVA coverage.

Standard COB

- Standard COB means KOVA processes the balance on the claim after the Primary's benefit has paid. Charges paid will not exceed what KOVA would have paid if primary.

Benefit less Benefit COB

- Benefit less Benefit COB means KOVA processes the claim using the member's KOVA benefit and then subtracts their primary benefit. If the primary carrier's benefit is greater than or equal to the KOVA benefit, no excess payment will be made. If the primary carrier's payment is less than the KOVA payment, then additional payment may be made based on the eligible amount and the plan design.

KOVA shall coordinate payment for covered services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance.

If KOVA is the secondary insurer, Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to KOVA.

Any balance due after receipt of payment from the primary payer should be submitted to KOVA for consideration and the claim must include information verifying the payment amount received from the primary payer.

COB information can be submitted to KOVA by an EDI transaction with the COB data completed in the appropriate COB elements. Only paper submitters need to send a copy of the primary insurer's explanation of benefits.

KOVA may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Members under the Medicare Advantage plans line of business may be covered under more than one insurance policy at a time. In the event:

- A claim is submitted for payment consideration secondary to primary insurance carriers, other primary insurance information, such as the primary carrier's EOB, must be provided with the claim. KOVA has the capability of receiving EOB information electronically.
- KOVA has information on file to suggest the Member has other insurance primary to KOVA 's, KOVA may deny the claim.
- The primary insurance has terminated; the Provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the Provider is responsible for submitting the initial claim with proof payment has been returned back to the primary insurance carrier.
- Benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds KOVA liability, no additional payment will be made.
- The services are related to an accident where no-fault or liability insurance is involved, KOVA will always be secondary.
- The condition being treated is due to a Workers' compensation/Job-related illness or injury, KOVA has no responsibility for payment.

GRIEVANCE AND APPEALS PROCESS

Appeals

An appeal is a request for KOVA to review a previously made decision related to medical necessity, clinical guidelines, or prior authorizations.

A treating physician may request a reconsideration on the Member's behalf. The appeal must be submitted *within 60 days of the original decision*. You must receive a notice of denial, or remittance advice before you can submit an appeal. With your appeal request, you must include an explanation of what you are appealing along with the rationale for appealing the initial decision.

You may send your appeal request via secure email to QualityImprovement@kovahealth.com or by mail to:

KOVA Healthcare, Inc.
Attn: Grievance and Appeals Resolution Department
7061 N. Whitney Ave. Suite 102
Fresno, CA. 93720

Grievances

KOVA recognizes that providers may encounter situations in which our operation does not meet their expectations. When this happens, the provider is encouraged to contact KOVA. KOVA will promptly consider all grievances also known as complaints by its providers.

Complaints are classified by KOVA into three categories:

- Administrative complaints: such as claim payment issues, balance billing, benefit applications etc.
- Medical complaints: such as denial of a referral, denial of certification.
- Quality of Care complaints: such as appropriateness of care, continuity of care or refusal of care.

The Medical Management Department addresses medical complaints. The Quality Management Department evaluates and resolves quality of care complaints. Administrative complaints are routed to the appropriate department.

Complaints are resolved in a timely manner at the department level. If the resolution of a complaint is unsatisfactory to the provider, he/she may file a written appeal. The written appeal should state the reason(s) for the provider's dissatisfaction with the original decision. Any additional information the provider wishes to have considered should be submitted with the written appeal.

Credentialing and Re-credentialing of Providers

Credentialing

KOVA credentials contracted providers to verify their professional qualifications. The Credentialing process includes but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications. KOVA has established policies and procedures to evaluate and approve Practitioners to participate in KOVA programs that, at minimum, meet the requirements of KOVA credentialing policies.

KOVA uses CAQH (Council for Affordable Quality Healthcare) for all credentialing activities. New providers joining the KOVA Network should complete the CAQH application online to begin the credentialing process. The CAQH Data Source is free and offers a fast and easy way for providers to securely submit their credentialing information to health plans and networks.

If you are adding a physician to your practice, contact our Contracting Department at 559-207-3198 or by email at AngelaS@kovahealth.com. Once the application has been received, Primary Source Verification is conducted to verify education, licensing, and board certification where applicable. Incorrect or incomplete applications must be corrected within 15 calendar days. Applications are reviewed and approved by KOVA's Executive Management and Quality Improvement Committee before the provider is deemed in-network.

Completed applications are credentialed within *120 calendar days of receipt* (typically sooner) and notified of final approval/disapproval within 30 calendar days of determination. KOVA ensures the confidentiality of credentialing information.

Re-Credentialing

KOVA may re-credential any participating provider within the scope of the network as often as every three years or as otherwise required. Approximately 3-6 months before the re-credentialing date, the application is obtained from CAQH, and we will contact the office if additional information is required.

Re-credentialing is similar to the initial credentialing process as the standard CAQH application will be reviewed. Providers will be notified of any discrepancies between re-credentialing applications and KOVA's review of the information allowing them a chance to submit additional materials to resolve any issues. All re-credentialing applications are reviewed and approved by KOVA's Executive Management and Quality Improvement Committee. Providers who fail to submit required credentialing documents in a timely manner may be terminated from the network and no longer eligible to see members.

KOVA monitors participating providers and reserves the right to terminate or suspend a provider from the network.

Monitoring can include, but is not limited to, reviewing Medicare or Medicaid sanctions, limitations on licensures, member complaints and information regarding adverse events or quality issues. If KOVA decides to suspend,

terminate, or not renew a physician contract, KOVA must provide at least sixty (30) calendar days written notice of the reasons for the action and notice of the right to hearing, the process, and the timing.

If you have questions about credentialing, please contact our Provider Relations Department:

- Email at AngelaS@kovahealth.com.
- Provider Portal at www.kovahealth.com
- Provider Call Center at 1-559-207-3198

Member Information

Member Identification

KOVA reimburses providers only for medically necessary covered services rendered to eligible members. A member ID Card does not guarantee member eligibility.

Member ID Card

Each covered member receives an ID card with the KOVA and/or Health Plan (Medicare Advantage) logo. Members are responsible for always carrying their KOVA ID cards with them. To receive benefits, members are to present these cards to their health care provider when they obtain medical services.

Covered Benefits

If there is a question as to whether the service or care is a covered/limited benefit, visit the KOVA website or call Member Services.

Member Rights and Responsibilities

KOVA members have the right to timely and high-quality care and to be treated with respect and dignity. Participating providers must respect the rights of all members.

Member Rights

- To be treated with dignity and respect and right to personal privacy recognized
- To have information about their diagnosis, treatment, and prognosis so they can have candid discussions with providers about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage and actively participate in decisions regarding their health and medical care
- To have timely access to their PCP, and if out of service area, receive emergency care, if necessary
- To have medical records kept confidential (except when disclosure is required by law or permitted by patient in writing) and have access to copies or request amendments to their medical records in accordance with HIPPA regulations
- To extend their rights to a guardian, next of kin or legally authorized person on their behalf
- To be advised of the probable consequences of their actions when they refuse treatment or leave a medical facility against the advice of their providers
- To receive information about the organization, its providers and services and their rights
- To exercise these rights regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, and/or source of payment for care

Member Responsibilities

- To be familiar with your plan and benefits and any rules that may apply
- To inform providers (to extent possible) of the information they may need to provide care and to follow treatment plans and instructions that you and your provider have agreed upon
- To ask any questions you may have of your provide

Primary Care Provider

Overview

KOVA Primary Care Providers are defined as a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services. KOVA requires members to select a Primary Care Provider.

The Primary Care Provider provides, coordinates, or is aware of all aspects of the member's health care and history. Primary care physicians shall not discriminate or differentiate in the treatment of members based on race, color, gender, age, religion, national origin, health status, or source of payment.

Responsibilities

The responsibilities of the primary care provider include:

- Providing primary care services to members
- Maintaining centralized medical records for applicable members
- Coordinating all aspects of members' health care
- Making referrals to appropriate participating providers, ancillary services and facilities as needed
- Providing 24-hour coverage with appropriate call coverage arrangements to ensure that health care services are available to members in the primary care physician's absence
- Meeting KOVA 's credentialing/re-credentialing requirements
- Following KOVA 's Utilization Management/Quality Improvement guidelines and adhering to its policies and procedures
- Notifying KOVA of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting KOVA 's products, procedures and other delivery system requirements
- Maintaining procedures to inform members of follow-up care or providing training in self-care as necessary
- Contributing to KOVA 's improvement and accomplishment of its goals and mission by voice, written word and committee involvement in a cooperative, collaborative manner

Panel Status

Unless otherwise notified, KOVA will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact KOVA to have the panel status updated.

Appointment Minimum Standards

- Waiting time for new member appointments - 4-6 weeks
- Waiting time for adult well appointment - 1 month
- Waiting time for semi-urgent care visits - 2-3 days
- Waiting time for urgent care visits - Same day
- Waiting time for new obstetrical appointment - 1 month
- Average waiting time to see physician from appointment time - 30 minutes or less

On-Call Requirement/Covering Provider

Primary care services must be available to KOVA members 24 hours a day, 7 days a week. When the primary care provider is unavailable, it is his or her responsibility to arrange coverage for KOVA members. The covering provider should report calls and services to the member's primary provider.

Covering providers, whether participating or not, must adhere to all administrative requirements and agree not to bill the member for services other than the copay, deductible, coinsurance or to the extent defined in the member's

benefit plan. It is the provider's responsibility to explain KOVA 's applicable billing, referral, and certification requirements to the covering provider.

If a covering provider sends a claim to KOVA, covered services may be reimbursed at the rate contracted with the primary care provider at the time the services were rendered, unless the primary care provider is covered under a capitation agreement.

Specialist Physicians

Overview

This section discusses the responsibilities of the KOVA Specialist Physician.

Responsibilities

Contact with the primary care physician should be maintained throughout the Specialist Physician's treatment of the member. In some KOVA products, such communication is required.

Specialists are responsible for the following:

- Meeting KOVA's credentialing/re-credentialing requirements
- Following KOVA's Utilization Management/Quality Management guidelines and adhering to its policies and procedures
- Notifying KOVA of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting KOVA 's products, procedures, and other delivery system requirement
- Maintaining procedures to inform members of follow-up care or providing training in self-care as necessary
- Contributing to KOVA 's improvement and accomplishment of its goals and mission by written word and committee involvement in a cooperative, collaborative manner
- Informing members that approved referrals are necessary for maximum benefits

Panel Status

Unless otherwise notified, KOVA will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact KOVA to have the panel status updated.

Facilities

Overview

Facility is defined as a party which includes any persons employed by such facility and any persons or entities that provide Covered Services to Covered Persons under such facility's tax identification number. The term includes affiliates of any Facility that provide Covered Services to Covered Persons which may have a unique tax identification number, but which the Facility either owns or controls.

Responsibilities

Facility will provide services in accordance with the terms of the contractual Agreement.

Work Stoppage

In the event of a work stoppage at Facility, Network agrees to work with the Participating Providers to defer elective admissions, and Facility agrees to cooperate with Network in using its best efforts to provide continuity of care to Covered Persons who have been admitted until normalization of operations at Facility

Disaster or Epidemic

In the event of any major disaster or epidemic, Facility agrees to render covered services insofar as practical according to its best judgment, within the limitations of those facilities and personnel which are available.

Medical Management

Overview

The purpose of the Medical Management program is to ensure that members receive the clinically necessary and appropriate care (including frequency of service and duration) in the right setting; the care is cost effective; and the care results in improved functional, clinical and financial outcome, all while following the client specific summary plan document, and local, state and federal guidelines.

Managed Care responsibilities include, but are not limited to, precertification, referral, determination of medical necessity, direction to in-network services, evaluation of protocol compliance and case management.

Utilization Management

KOVA Healthcare, Inc. (KOVA) KOVA Medicare Advantage s (UM) Utilization Management (UM) Program takes a multi-disciplinary approach to balancing clinical effectiveness, quality outcomes and risk concerns in the provision of patient care. It is the policy of KOVA to systematically monitor and evaluate the UM Program, act on opportunities for improvement, and resolve identified issues on an ongoing basis. KOVA ensures that the appropriate non-behavioral, behavioral and pharmaceutical care and services are delivered timely, and in accordance with the applicable state and federal regulations set out by the Centers for Medicare and Medicaid Services (CMS), California Department of Managed Health Care (DMHC), as well as National Committee for Quality Assurance (NCQA) standards.

Department Functions

- Prior Authorization
- Concurrent Review
- Case Management
- Disease Management

The Utilization Management Program determines if non-behavioral (medical), behavioral and pharmacy services are:

- Covered under the Member's Benefit Plan
- Medically Necessary and appropriate
- Performed at the most appropriate setting for the Member.

KOVA affirms that it encourages appropriate utilization of Medically Necessary Member care and discourages over- and under-utilization of services by the following statements:

- UM decision making is based only on appropriateness of care and service and existence of coverage
- KOVA does not reward Providers or other individuals for issuing denials of coverage or service care
- Financial incentives for UM decision makers do not encourage decisions that result in over- or under-utilization
- Providers are not prohibited from acting on behalf of the Member
- Providers cannot be penalized in any manner for requesting or authorizing appropriate medical care
- Providers are ensured independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion, or any other similar matters.

Nothing contained in the Agreement, this Provider Manual, the Utilization Management Program description, and related policies and procedures (P&Ps) is intended or shall be construed to interfere with the professional relationship between a Member and their physician(s), including the physician's ability to discuss treatment options with the Member or an advocate for the Member. Providers likewise may not prohibit Members from completing surveys and/or otherwise expressing their opinion regarding services received from providers.

Medical Necessity

Medically Necessary or Medical Necessity is defined as those Covered Services that are:

- Necessary for the diagnosis or treatment of a medical condition
- Provided in a manner consistent with professionally recognized healthcare standards

- Requested and authorized in accordance with applicable KOVA policy and other administrative requirements of the DMHC, CMS or other regulatory agencies
- The most appropriate supply or level of service which can be safely provided
- Not provided primarily for the convenience of a member, his/her family, Provider Group, Hospital or the Member's Hospital Provider.

If this definition conflicts with a definition of Medically Necessary services required by any regulatory agency that oversees contracted KOVA operations, that regulatory definition shall supersede the above definition.

Utilization Management Criteria and Guidelines

Utilization Management Criteria and Guidelines are clinical references used to educate and support clinical decisions by Providers at the point of care in the provision of acute, chronic, and behavioral health services. Utilization Management Criteria and Guidelines assist Providers in providing Members with evidence-based care that is consistent with professionally recognized standards of care.

KOVA, contracted Provider Groups, and Non-delegated Provider Groups ensure that criteria and practice guidelines and UM activities and decisions:

- Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field
- Consider the needs of the enrolled population
- Are developed in consultation with contracted Providers
- Are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Quality Oversight (QO) Committee voting physician members for review and approval.

KOVA, contracted Provider Group, and Non-delegated Provider Group conducts utilization review using criteria and guidelines that are approved and adopted in the KOVA UM Program. KOVA and its Providers must follow the hierarchy when making coverage determinations:

- Nationally recognized Evidence Based criteria, such as Contracted Clinical Criteria Set Application
- Medicare Manual of Criteria
- Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines
- Medicare Part D: CMS-approved Compendia
- National Guideline Clearinghouse
- National Comprehensive Cancer Network (NCCN) Guidelines
- Transplant Centers of Excellence guidelines
- Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines
- Preventive health guidelines, such as U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines).

Medical, behavioral health and pharmacy review criteria are based upon nationally recognized guidelines, including but not limited to Contracted Clinical Criteria Set Application, CMS, and professional association guidelines. If there is a conflict between our policies and the CMS Medicare Coverage Center guidance, the CMS Medicare Coverage Center guidance controls.

KOVA and Provider Groups apply criteria based on individual needs. KOVA considers the following characteristics when applying criteria to each Member: age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable.

KOVA and Provider Group apply criteria based on an assessment of the local delivery system. KOVA considers available services in the local delivery systems and their ability to meet the Member's specific health care needs, when utilization management criteria are applied, including but not limited to:

- Availability of inpatient, outpatient, and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as surgery centers vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers

- Availability of skilled nursing facilities, subacute care facilities or home care in KOVA 's service area to support the patient after hospital discharge
- Local hospital's ability to provide all recommended services within the estimated length of stay.

Prior Authorization

The purpose of prior authorization is to ensure that the proposed services are medically necessary and that the level of care is appropriate. This process provides KOVA an opportunity to assess the Member's condition, identify potential discharge planning needs, provide transitional care support, refer for care management services, and assist with the coordination of other special needs so that early intervention is assured. KOVA uses established criteria and regulatory guidance to make these determinations, and, if the criteria are not met, the Medical Director is consulted for a determination.

KOVA requires authorization of certain services, Part B covered medications/biologics, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care.

The authorization is typically obtained by the ordering provider but may also be requested by the rendering provider. Providers are responsible for requesting Prior Authorization on behalf of the Member when required. Requests must include all pertinent clinical information to support the medical necessity of the services requested. A Member may also request a determination prior to delivery of services. In this event, KOVA will contact you for clinical information to support the request.

Please refer to the Authorization portal located at www.kovahealth.com/provider-resources. The presence or absence of a service or procedure on the list does not determine coverage or Benefits. You may also visit https://www.cms.gov/ to check for covered services and procedure codes valid for Medicare.

For your convenience, register for access to our Provider Portal to submit prior authorization requests and obtain status of existing prior authorization requests. The Provider Portal is available at www.kovahealth.com/provider-resources.

Prior authorization requests may also be submitted:

- via fax Attention: KOVA Utilization Department to:
  - Prior Authorizations - FAX#: 559-207-3901
  - Misc. Records - FAX#: 559-207-3901
  - Inpatient Authorizations - FAX#: 559-207-3901
- by phone at 559-207-3198, menu option #2
- by mail: 7061 N. Whitney Ave Suite 102, Fresno CA. 93720

If you are uncertain about the precertification requirement for a specific procedure, you may reach out to:

- 1-559-207-3198, menu option
- or fax to Attention: KOVA Utilization Department at 559-207-3901
- Phones are staffed Monday-Friday from 8 a.m. – 5 p.m. pacific time.

Prior authorization requirements will be routinely updated on a quarterly basis due to program or CPT/HCPCS coding changes. It is recommended that you check the authorization requirements via the website frequently and prior to delivering planned services. Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status, and benefits at the time the service is rendered.

About our Utilization Management Team

The Utilization Management Team consists of nonclinical and clinical support staff trained to receive requests via Provider Portal, fax, telephone and mail. Pertinent information will be requested in order to efficiently and accurately

process the medical necessity determination. Upon submission of the request, please be prepared with all necessary information noted above inclusive of accurate diagnosis, CPT/HCPCS coding, and rendering provider information.

As necessary, service requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity, appropriateness of provider and place of service. Requests that cannot be approved utilizing CMS and nationally recognized, evidence-based criteria will be forwarded to a Medical Director for review. Approval notification may be delivered electronically, orally, or in writing.

Denials for medical necessity are issued only by appropriately licensed personnel such as a Medical Director or Associate Medical Director. He/she may also make a decision based on administrative guidelines. The Medical Director or Associate Medical Director, in making the decision, may suggest alternative covered services to the requesting provider. If the Medical Director or Associate Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, KOVA notifies the facility or providers office of the denial, as well as the Member.

The written denial notice includes the original request that was denied, the rationale for the decision, the alternative approved service if applicable, and the process for appeal. Denial rationale will include the specific clinical criteria or benefits provision used in the determination of the denial. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or patient. Upon request, the provider or Member may receive a copy of the clinical criteria used in the decision.

An Advanced Beneficiary Notice (ABN) may not be used to hold Members liable for services unless a preservice adverse organization determination has already been rendered and communicated in writing via an Integrated Denial Notice (IDN) or the Member's EOC clearly excludes the service from covered services.
KOVA in no way rewards or incentivizes, either financially or otherwise, individuals involved in conducting reviews, for issuing denials of coverage or service or inappropriately restricting care.

Emergency Care

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the life or health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Or serious dysfunction of any bodily organ or part.

Prior Authorization is never required for Emergency Services, including behavioral health services necessary to screen and stabilize Members.

Expedited Requests

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined, and notification will occur within 72 hours of receipt of the request or as soon as the patient's health condition requires.

In order to assist us in best meeting our member's urgent needs, it is recommended that expedited requests be reserved for services meeting the above criteria and not utilized as a convenience due to a scheduled service.

An expedited request may not be requested for cases in which the only issue involves a claim for payment for services that the Member has already received.

Standard Requests

A routine or standard Prior Authorization request will be determined, and notification will occur as expeditiously as the Member's health condition requires, but no later than 14 calendar days after receipt of the request. All elective admissions rendered at or by a facility (in-network or out-of-network) shall be pre-authorized at least ten (10) business days prior to the admission or surgery or as soon as the admission or procedure is planned.

Requiring Prior Authorization for specific services does not indicate or imply the service is Covered Service. Coverage is determined by the Member's Benefit Plan.

Prior to the date of service(s), the requesting Provider shall confirm Prior Authorization approval is on file and notify KOVA for inpatient services.

Concurrent Review

Concurrent review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of care during observation, inpatient (acute, long term acute care, rehabilitation), skilled nursing facility admissions, and home and community-based services in order to ensure covered services or supplies are being provided at the appropriate level of care, to identify and monitor quality of care issues, and to assess discharge planning and care management needs.

Established criteria are used to make these determinations, and, if not met, the Medical Director or Associate Medical Director is consulted. KOVA shall not conduct utilization review more frequently than is reasonably required to assess whether the health care services under review are medically necessary.

All requests for admission, including observation and inpatient level of care, are subject to medical necessity review. Observation level of care is an alternative to an inpatient admission that allows reasonable and necessary time to render medically necessary services and evaluate Member response to services before a decision to admit or discharge can be made. KOVA requires admission notification for the following:

- Elective admissions
- ER and Urgent observation and acute admissions
- Intent to Transfer to Acute Rehabilitation, LTAC and SNF as those admissions require pre- authorization
- Observation and Acute admissions following outpatient procedures

Emergent or urgent admission notification must be received within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the patient's condition is unstable and the facility is unable to determine coverage information, KOVA requests notification as soon as it is determined, including an explanation of the extenuating circumstances.

Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

KOVA 's preferred method for Concurrent Review is through Electronic Medical Records access. Concurrent review documentation can also be received via fax. Live dialogue between a member of our UM nursing team and the facility's UM staff is encouraged to assist with discharge planning and needs. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information KOVA has available.

Facilities may fax the patient's clinical information within 24 hours of notification to 559-207-3907. Following an initial determination, the UM Nurse will request additional updates from the facility on a case-by-case basis. The criteria used for the determination is available to the practitioner/facility upon request. KOVA will render a determination within 24 hours of receipt of complete clinical information. KOVA 's UM Nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a determination. Clinical update information should be received 24 hours prior to the next review date.

All acute, rehab, LTAC, and SNF confinements that do not meet medical necessity criteria are reviewed by a Medical Director or Associate Medical Director and a determination is issued. If the Medical Director or Associate Medical Director deems that the inpatient or SNF/Rehab confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The UM Nurse or designee will notify the provider(s) e.g., facility, attending/ ordering provider, and Member verbally and/or in writing of the adverse determination via notice of denial.

Skilled Nursing Facility notice of Medicare non-coverage (NOMNC)

All Skilled Nursing services that do not meet medical necessity criteria are reviewed by the Medical Director or Associate Medical Director for determination. If the Medical Director deems that the services are not medically necessary, the Medical Director will issue an adverse determination (a denial). The UM Nurse or designee will notify the provider and member verbally and/or in writing of the adverse determination via notice of denial.

It is the Skilled Nursing Facility's responsibility to issue the written Notice of Medicare Non-Coverage (NOMNC) in accordance with CMS guidelines when a discharge from care is anticipated. KOVA will issue a NOMNC with adverse organization determinations/denials when it is anticipated that services will end. The skilled nursing provider is responsible for delivering the notice to the Member or their authorized representative/power of attorney (POA) at least 2 calendar days prior to the end date of the currently approved authorization. A NOMNC must be delivered even if the Member agrees with the termination of services. The provider is responsible for ensuring the patient, authorized representative or POA signs the notice within the specified time frame. The NOMNC includes information on patient's rights to file a fast-track Appeal.

If the provider believes continued skilled nursing services are required, a request for additional services must be submitted prior to the expiration of the existing authorization. The skilled nursing provider is required to send a copy of the signed NOMNC back to KOVA promptly in order to ensure the Member's rights to file a fast- track Appeal are preserved.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines/ criteria to support the claim adjudication process after the opportunity for prior authorization or concurrent review timeframe has passed. The only scenarios in which retrospective requests can be accepted are:

- Authorizations for claims billed to an incorrect carrier provided you have not billed the claim to KOVA and received a denial. Note: If the claim has already been submitted to KOVA and you have received a denial, the request for retro authorization then becomes an Appeal and you must follow the guidelines for submitting an Appeal.
- KOVA will retrospectively review any medically necessary services provided to KOVA Members after hours, holidays, or weekends. KOVA does require the retro authorization request and applicable clinical information to be submitted within 1 business day of the start of care.

UM staff will review all pertinent records for medical necessity and level of care using established reference guidelines. When an approval for services cannot be made by the appropriate UM staff, the KOVA Medical Director or Associate Medical Director will review the case and make a determination. Only physicians have the authority to deny or modify requests for service. All retrospective decisions are completed within 30 calendar days after the receipt of request.

Notice Requirements

Notification of determinations will occur within the following timelines

- For non-urgent pre-service/standard decisions - within 14 calendar days of the request or as expeditiously as the Member's health condition requires.
- For urgent pre-service/expedited decisions - *within 72 hours of receipt of the request.
- For urgent concurrent decisions - *within 24 hours of the request.
- For post-service (retrospective) decisions - within 30 calendar days of the request.

KOVA complies with CMS requirements for written notifications to Members, including rights to appeal and grievances. Member Notices must be written at lower than an eighth (8th) grade reading level, be complete and accurate, including adequate rationale specific to the decision, and written in a manner easily understandable to the Member, and not subject to interpretation. Notification of denial must include a citation to the criteria used, rationale, and the recommendations for alternative and/or follow up with the Provider. Notices must not use acronyms or technical/clinical terms unless an explanation and/or definition is provided.

Case Management

The Plan provides for special handling of catastrophic and long-term care cases. This feature is designed to assure that care is provided in the most appropriate and cost-effective care setting. Case Management is a cooperative effort between the member, the Physician, the member's family, and KOVA. It also allows KOVA to customize benefits by approving otherwise non-covered services or arranging an earlier discharge from an inpatient setting for a patient whose care should be safely rendered in an alternate setting.

KOVA Nurse Case Managers work to reach out to members after discharge from the inpatient setting based on specific screening criteria. Your involvement as a provider is extremely valuable to their efforts. Often, they rely on your records to update their own care plans. They will also reach out to your office to communicate care plan goals to collaborate on assisting the member with meeting their goals. You may see letters written to your office highlighting a mutual patient's KOVA Case Management care plan. Please call the Case Manager if you have any questions.

Disease Management

Members with a chronic illness such as heart disease or diabetes account for a very high proportion of healthcare dollars and services. Opting into the disease management program allows the plan to provide a focused effort of resources into the management and education of the member in programs designed to improve their health and reduce costly and tragic complications associated with their chronic illnesses.

If a member has an illness that falls into one of KOVA 's Disease Management Programs, the member may receive specialized educational materials regarding this illness from time to time. A member may be contacted by mail, telephone or electronic means to participate in meetings or programs designed to improve their health. KOVA may use one or more of its Business Associates to perform these functions. To the extent permitted by law, a listing of names, addresses and phone numbers may be shared with KOVA 's Business Associates.
These lists will be maintained with the strictest of confidentiality as required by law and will not be used or sold with the intent of solicitations or for any purpose outside the scope of Disease Management.

Additionally, KOVA will collaborate with the provider network to maximize in their initiatives toward disease management as much as possible. Recognizing that managing risks to the health of the member population is of utmost importance, Disease Management is a cooperative effort.

Denials and Appeals

- In the event a medical service is not approved, the process requires that the member is notified in a timely manner of the reason for the denial
- A member whose referral or certification request is not approved has the right to appeal such adverse determination in accordance with KOVA 's appeal procedure.

KOVA 's criteria or guidelines include but are not limited to:

- Clinical Criteria Set Application (e.g., MCG®) – we use these guidelines to help make decisions on allocation of services based on members' medical conditions. They are nationally recognized, and evidence based.
- NCCN – National Comprehensive Cancer Network – these are nationally recognized recommendations for the care of cancer. These are treatment plans for services of cancer by site along with supportive cancer treatment care and principles of adjuvant care such as monitoring, imaging, etc. Many oncology practices utilize NCCN to guide their prescribing.

- FDA – We focus on ensuring services and therapies are certified by the FDA if they are new to the market or not common to certain diagnoses.
- Center for Medicare and Medicaid Services (CMS) – If coverage for a certain service is indeterminable based on guidelines or available criteria, we may refer to the Center for Medicare and Medicaid Services to see if coverage is provided as a guide to assist in our final decision-making.
- Medicare Part D: CMS-approved Compendia
- National Guideline Clearinghouse
- Transplant Centers of Excellence guidelines
- Specialty society guidelines, such as American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines
- Preventive health guidelines, such as U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines).
- KOVA Clinical Guidelines – Established by the KOVA Medical Management staff, validated by the Quality Oversight Committee; for services with little to no formalized criteria from the entities above, or for services with KOVA -specific limitations.

Review criteria are available onsite and when permitted by license, will be distributed on request. Criteria is reviewed regularly to ensure that the most recent versions are being utilized and are approved.

Quality Management Program

Overview

The (KOVA) Quality Management Program (QMP) strives to improve the quality of health care and administrative services offered to members, physicians and employers. It does so through the establishment of a formal process and an infrastructure for continuously monitoring, evaluating and improving the health care and administrative services provided under all managed medical products. KOVA places great emphasis on the QI process because it is the organization's desire to assure that the quality of clinical and administrative services provided to KOVA members is continuously improving.

Quality Management Committee (QMC)

The committee is comprised of KOVA Medical Directors, Network Providers, and KOVA leadership. Functions of the QMC include but are not limited to:

- Oversight of KOVA quality management activities, with recommendations for improvement, as appropriate.
- Systematic, ongoing monitoring and evaluation processes to identify opportunities for improvement.
- Establishment of medical policy.
- Maintenance of disease management protocols.
- Oversight and approval of credentialing and re-credentialing activities.

Medical Record Guidelines

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. Medical record review is one aspect of Provider oversight conducted to assess and improve the quality of care delivered to Members and the documentation of such care. The focus of the review may include, without limitation, patient safety issues, clinical and/or preventive guideline compliance, over- and under- utilization of services, confidentiality practices and inclusion of consideration of Member input into treatment plan decisions.

The review process allows for identification of the Provider's level of compliance with contractual, accreditation and regulatory standards. Provider training is conducted as needed to facilitate greater compliance in future assessments. The medical record review is completed at a minimum annually and/or as needed. Results will be tabulated and shared with the practitioner and/or the Health Plan. Scores resulting in < 80% will require a Corrective Action Plan (CAP). Providers will have 30 calendar days to respond to CAP requests. Audit results are presented to the KOVA QMC committee.

Medical records maintained by Providers must be comprehensive and reflect all aspects of care for each Member. Records are to be maintained in a secured location. Documentation in the Member's medical record is to be completed in a timely, legible, current, detailed, and organized manner which conforms to good professional medical practice. Records must be maintained in a manner that permits effective, professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment.

Complete medical records include:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare professionals' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of service provided
- Medical records must be signed and dated.

A medical record of a clinical encounter/office visit must minimally include:

- Chief complaint
- History and physical examination for presenting complaint
- Treatment plan consistent with findings
- Disposition, recommendations and/or instructions provided

Notes should indicate follow-up care, telephone calls or visits. A specific time for the follow-up should be noted in weeks, months or as needed.

Follow-up documentation should indicate:

- Adverse clinical findings
- Unresolved problems from previous office visit
- If a consultation had been requested, there is a note from the consultant
- Results of studies ordered should be filed in the chart and initialed by the primary care physician to signify review
- Discharge summaries include condition at time of discharge and post-operative, or post- discharge instructions given to the patient
- Emergency care

Health education, preventive services, recommendations, and wellness counseling should be clearly noted and incorporated in the progress notes or in a specially designated section.

These services should be documented as applicable:

- Smoking cessation and alcohol or substance abuse.
- Immunizations
- Pap smear
- Breast exam and/or mammogram
- Colon cancer screening
- Medication compliance

Confidentiality of Member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to KOVA or its representatives without a fee to the extent permitted by state and federal law. Providers should have procedures in place to permit the timely access and submission of medical records to KOVA upon request.

HEDIS Measures and Reporting

HEDIS stands for the Health Care effectiveness Data and Information Set, which is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care. It allows for assessment based on quality and performance. Altogether HEDIS consists of 96 measures across six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

KOVA is required to report HEDIS to Centers of Medicare and Medicaid Services (CMS) annually. Each year health plans collect and report HEDIS data through a series of coordinated activities, including computer programing, encounter and claims analysis, and data integration through a certified HEDIS software vendor.

Depending on the measure, KOVA may be required to retrieve medical records from the provider offices to validate whether the service is documented. Providers' collaboration in these efforts is necessary in order to successfully fulfill our state and federal regulatory obligations.

Never Events, Serious Reportable Events, and Hospital Acquired Conditions

KOVA reviews inpatient claims to identify eight (1) specified hospital-acquired conditions, as defined by the National Quality Forum. KOVA does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Patients likewise are not responsible for payment.

In addition, the health plan and its members do not pay any charges related to three never events (2) or for a set of eight (3) serious reportable events, also defined by the National Quality Forum.

If a "never event" or a serious reportable event occurs, KOVA requires hospitals in its network to notify the health plan, along with at least one of three designated patient safety organizations: The Joint Commission; the state reporting program for medical errors; or a patient safety organization such as a state-specific patient safety center.

KOVA 's Quality Management Department reviews all identified never events and serious reportable events and follows up with individual facilities. Facility representatives must identify root causes of never events and serious reportable events, and the must identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.

A The eight specified hospital acquired conditions, as defined by the National Quality Forum, are as follows:
unintended retention of a foreign object in a patient after surgery or other procedure;

1. Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
2. Failure to identify and treat hyperbilirubinemia in neonates;
3. A burn incurred from any source while being cared for in a healthcare facility;
4. Intravascular air embolism that occurs while being cared for in a healthcare facility;
5. Medication error;
6. A fall while being cared for in a healthcare facility; and
7. Deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures: total knee replacement and hip replacement.

B The National Quality Forum defines a "never event" as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a healthcare facility." For purposes of this policy, KOVA and/or Health Plan defines the following events as never events:

1. Surgery or invasive procedure performed on the wrong person;
2. Surgery or invasive procedure performed on the wrong side or body part;
3. Performance of the wrong surgical or invasive procedure.

C KOVA will not pay facilities for a set of eight serious reportable events, as defined by the National Quality Forum:

1. Unintended retention of a foreign object in a patient after surgery or another procedure;
2. Patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products;
3. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;
4. Intraoperative or immediately post-operative death in an ASA Class I patient; Patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a healthcare facility; Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates;
5. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances; and
6. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.

Pharmacy Services

Overview

This section provides a summary of the KOVA Pharmacy Procedures and is designed to assist you and the member's Pharmacy in filing claims for services rendered to KOVA members.

KOVA Medicare Advantage administers Part D benefits for KOVA plans.

KOVA Pharmacy Services

Pharmacies can conduct the following transactions on-line

- Member Eligibility verification
- Drug pricing information
- Deductible/co-pay/co-insurance calculations
- Coordination of Benefit determinations
- Drug interaction analysis
- Automatic claim filing with KOVA

Covered Prescriptions

- Drugs which by Federal Law require a prescription and have received FDA approval for the intended use
- Insulin and insulin syringes
- Compounded medications that include at least one Federal Legend Drug or State Restricted Drug in a therapeutic amount
- Drugs covered under member benefits

Formulary

KOVA 's formulary is a list of generic and brand name drugs reviewed and approved by our PBM's Pharmacy and Therapeutics Committee and CMS to be covered as a pharmacy plan benefit. The formulary is updated monthly throughout the year. Please check the KOVA website on a regular basis to obtain current formulary information at www.kovahealth.com/formulary.

Days' Supply/Refills

KOVA Medicare Advantage s (KOVA)

KOVA has 30 or 90-day options to supply or refill prescriptions at retail pharmacy locations or via mail order.

Pharmacy Prior Authorization

KOVA requires certain drugs to have prior authorization or a letter of medical necessity. This process is administered through www.kovahealth.com/provider-resources..

It is important to submit the prior authorization at the time the prescription is written so that a member's prescription is not denied when being filled at the Pharmacy. Telephonic requests are processed the same day they are received. All requests are processed within 72 hours*.

* If you believe that waiting 72 hours for a standard decision could seriously harm the Member's life, health, or ability to regain maximum function, you may assist the Member in asking for an expedited decision.

Formulary Exceptions Process

For any Members participating in a treatment plan that requires a medication that was on the formulary at the beginning of the year, but was later removed, or Members requesting coverage of a non-formulary medication, please call KOVA Provider Services at 559-207-3918 to ask for information about the exceptions process or fax the Medicare Prescription Drug Coverage Determination Form to 559-207-3901. You may also download the Medicare Prescription Drug Coverage Determination Form, found at www.kovahealth.com.

Step Therapy Programs

KOVA health plans use pharmacy step therapy programs, which require members to try generic or preferred brand medications before being allowed to use non-preferred brands. Both the applicable member and physician will receive advanced communication about such programs before they are effective.

Sample Member Card