RANGE HEALTH

Provider Manual

Form No. 9-3623-RGH (07-25)

©Range Health

RANGE HEALTH

Table of Contents

Access to Care Guidelines

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete , or modify this policy in accordance with our provider contracts.

Policy

The provider agrees to facilitate reasonable access to medical care for plan members. The following time frames should be adhered to, to provide reasonable access to care. These time frames consider the member's need and common waiting times for comparable services in the community.

Preventive care appointments for wellness exams and immunizations	**42 calendar days**
Routine assessment appointment for follow-up evaluations of stable or chronic conditions	**30 calendar days**
Non-urgent medical care appointments for treatment of stable conditions	**7 calendar days**
Urgent appointments for treatment of illnesses or injury requiring immediate attention	**Immediately**
Waiting time in provider's office for scheduled appointment	**Less than 45 minutes**
Available 24-hour coverage provided by physician or on-call arrangement	**Referral to the emergency room is not acceptable**

Provider Relations will notify the provider's office in writing if notification is received and confirmed that the office is not able to comply with the Access to Care Guidelines as listed above.

If you feel you cannot meet the access to care guidelines as specified above, please contact your Provider Network Management Specialist to discuss your options.

Policy History

Date	Action	Reason

Availability

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The provider or designated covering provider agrees to provide medically necessary services 24 hours a day, 7 days a week for Medicare Advantage members, or to direct members to the setting most appropriate for treatment. The provider agrees to establish call-share arrangements with another provider to ensure 24-hour availability.

If changes are made in call-share arrangements, please notify Range Health Provider Relations to ensure claims from covering providers are processed correctly. If the provider office uses an electronic answering machine, the message for the caller should include the name, phone number, and contact instructions for the on-call physician.

Policy History

Date	Action	Reason

Behavioral Code of Conduct

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health values the important relationships we hold with the providers in our community. While the strength of our partnership is grounded in our shared goals, we realize situations will inevitably arise in which the parties disagree with one another. Despite our disagreements, both parties must act with professional integrity and mutual respect working with one another toward the common goal of serving our members. At no time shall either party endure harassment, bullying or disparaging comments made in a private conversation, public forum, or in any form of communication.

Examples of Inappropriate Behavior:

- Physical- any form of physical violence or threatening gestures
- Verbal- use of threatening or intimidating language
- Emotional- behaviors aimed at belittling, humiliating, or demeaning individuals
- Bullying/harassment- aggressive behavior, verbal, or physical attacks
- Cyberbullying- abusive or harmful communication conducted through electronic or social media platforms

If a Range Health employee experiences inappropriate behavior from a provider partner or any person representing their practice, the behavior will be reported to the Provider Relations Manager or escalated to the Director, who will, in turn, contact the provider office. Next steps will be determined through the course of the investigation and conversation. If the offending party is an employee or contractor of our provider partner, the provider partner will be tasked with addressing the situation directly with the employee or contractor. Depending on the nature and severity of the behavior, the offending party could face disciplinary action up to and including loss of credentials and contracts with Range Health or referral to law enforcement agencies, if necessary.

Policy History

Date	Action	Reason

Billing Guidelines for Intensity Modulated Therapy (IMRT)

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Intensity Modulated Radiation Therapy (IMRT) is a form of radiotherapy that delivers a precise dose of radiation to targeted areas with minimal exposure or damage to surrounding healthy tissue. With IMRT, a computer controls the size and intensity of the radiation beams as they enter a patient's body from various angles. While IMRT is a technique for delivering radiation doses, it is not clinically indicated for treatment of all cancers. It has proven to be most effective in treating cancers of the head, neck and prostate where the site of the tumor can be stationary during treatment, making it easier to target the treatment beams and protect surrounding tissue.

IMRT services require prior authorization.

Please refer to these guidelines to understand how we may edit your IMRT claims once submitted to Range Health.

CPT Code	Description
CPT 77427	(Radiation treatment management, 5 treatments) - is only reported once per every five treatment sessions; preferably at the conclusion of those five treatment sessions, or in the event the entire course of treatment is complete, it may be used for three or more sessions.
CPT 77336	(Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy) - is only reported once per week of therapy; preferably at the end of each week.
CPT 77334	(Treatment devices, design and construction; complex) - is only reported once per treatment device per course of therapy used in IMRT delivery. Treatment

	devices used in radiation oncology are customized blocks or shields to protect healthy tissue surrounding the treatment area and are made from energy-absorbing material. Range Health may investigate occurrences of CPT 77334 with more than ten billing units.
CPT 77300	(Basic radiation dosimetry calculation, central axis depth dose calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician) - is reported once per every dosimetry calculation. Range Health may investigate occurrences of CPT 77300 with more than ten billing units.
CPT 77301	(Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) - is reported once per course of therapy to a specific area.
CPT 77418	(Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session) – is reported once per IMRT treatment session.
CPT 77338	(Multi-leaf collimator device(s) for intensity modulated radiation therapy design and construction per IMRT plan) - is reported once per course of therapy.

National Correct Coding Initiative (NCCI) bundling edits will occur for all same day services billed in conjunction with CPT codes 77301, 77338 and 77418 for both professional and facility claims. Additionally, we will edit facility claims containing CPT 77301 against CMS guidelines that package several CPT codes with IMRT planning because they are all part of planning regardless of whether they occur on the same day.

IMRT delivery should be preceded by IMRT planning. To mix standard radiation planning and treatment with IMRT planning and treatment is incorrect billing.

Policy History

Date	Action	Reason

Billing Requirements for Federally Qualified Health Centers (FQHCs)

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

This information applies only to Federally Qualified Health Centers (FQHCs) when submitting claims for qualifying visits under the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System (PPS). FQHC services not covered under the PPS rate, such as other preventive services performed on the same day as the initial preventive physical exam (IPPE) or Medicare annual wellness visit (AWV), are subject to the Range Health payer rules. Traditional non-covered Medicare services that Range Health covers as a Medicare Advantage Organization should be billed separately in the electronic CMS-1500 format for benefit consideration. FQHC claims submitted for qualifying visits under the CMS PPS must be billed under type of bill (TOB) 77X and include revenue code(s) 0519, 0521, 0522, 0524, 0525, 0527, 0528 and/or 0900.

FQHC claims for any of the following qualifying services rendered to Range Health Medicare Advantage (MA), patients must also include the corresponding CMS PPS payment code (HCPC):

Qualifying Services	CMS PPS Payment Code (HCPC)
92002, 92004, 97802, 99201-99205, 99304-99306, 99324-99328, 99341-99345, 99406, 99407, 99495-99497, G0101, G0102, G0108, G0117, G0118, G0296, G0442-G0447, G0490, Q0091	G0466 – FQHC New Patient
92012, 92014, 97802, 97803, 99212-99215, 99304-99309, 99310, 99315, 99316, 99318, 99334-99337, 99347-99350, 99406, 99407, 99495-99497, G0101, G0102, G0108, G0117, G0118, G0270, G0296, G0442-G0447, G0490, Q0091	G0467 – FQHC Established Patient

99495, 99496, G0402, G0438, G0439	G0468 – FQHC Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV)
90791, 90792, 90832, 90834, 90837, 90839, 90845, 99495, 99496	G0469 – FQHC Mental Health Visit, new patient[1]
90791, 90792, 90832, 90834, 90837, 90839, 90845, 99495, 99496	G0470 – FQHC Mental Health Visit, established patient
Revenue code 052x	G0511 – Chronic Care Management (CCM), Behavioral Health Integration (BHI)
Revenue code 052x	G0071 – Virtual Communication Services (VCS)
Revenue code 052x	G0512 - Psychiatric Collaborative Care Model Services (CoCM)
Revenue codes 052x or 0900	G2025 – telehealth encounter visit)

FQHC claims submitted for any of the above listed qualifying services without the appropriate TOB, revenue code and corresponding HCPC will be denied and returned for corrected billing. This list of qualifying services serves only as an example. Refer to the CMS website for updates or more information.

[1]If a new patient receives both medical and mental healthcare on the same day, the patient is considered“new” for only one of these visits. FQHCs should not use G0469 to bill the mental health service received on the same day as a new patient medical service. Instead, services should be billed as G0466 for new patient medical services and G0470 to bill for mental health services.

FQHC telehealth claims must be submitted with FQ modifier. The list of telehealth services that Range Health will consider for telehealth services are listed in the Medicare telehealth list or described as a telehealth code in the CPT code description.

Range Health follows Medicare guidelines regarding the billing requirements and proper coding for services provided to Range Health MA CMS offers frequently asked questions (FAQs) regarding FQHC billing requirements. Refer to the CMS website for more information.

Policy History

Date	Action	Reason

Billing Requirements for Rural Health Centers (RHCs)

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

This information applies only to rural health centers (RHCs) when submitting claims for qualifying visits under the Centers for Medicare and Medicaid Services (CMS) prospective payment system (PPS). RHC services not covered under the PPS rate, such as other preventive services performed on the same day as the initial preventative physical exam (IPPE) or Medicare annual wellness visit (AWV), are subject to the Range Health payer rules. Traditional Medicare non-covered services that Range Health covers as a Medicare Advantage Organization (MAO) should be billed separately in the electronic CMS-1500 format for benefit consideration. RHC claims submitted for qualifying visits under the CMS PPS must be billed under Type of Bill (TOB) 71X and include revenue code(s) 0521, 0522, 0523, 0524, 0525, 0527 and/or 0900.

RHC claims for any of the following qualifying services rendered to Range Health Medicare Advantage (MA), patients must also include the corresponding revenue code. RHCs must report one service line per encounter/visit with the appropriate CPT/HCPCS and revenue code.

RHC Service	Qualifying CPT	Qualifying Revenue Code
Qualifying Services – Medical[1]	92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349,	052X

	99350, 99495, 99496, 99497, G0490	
Qualifying Services - Preventative	G0101, G0102, G0117, G0118, G0296, G0402, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, Q0091, 99406, 99407 Chronic Care Management 99490 is allowable billed alone or with another payable service on an RHC claim	052X
Advanced Care Planning (ACP)	99497, 99498	052X
Qualifying Services - Mental Health	90791, 90792, 90832, 90834, 90837, 90839, 90845, 99495, 99496	0900
Chronic Care Management (CCM), Behavioral Health Integration (BHI)	G0511	Revenue code 052x
Virtual Communication Services (VCS)	G0071	Revenue code 052x
Psychiatric Collaborative Care Model Services (CoCM)	G0512	052x
Telehealth Services	G2025 **must* be *billed with FQ modifier*	052x

[1]Additional services may apply. Refer to the current CMS RHC Qualifying Visit list on the CMS website at Rural Health Clinics Center / CMS.

RHC claims submitted for any of the qualifying services listed above without the appropriate TOB, revenue code and corresponding CMS PPS payment code will be denied and returned for corrected billing. The list of qualifying services serves only as an example. Please refer to the CMS website for updates or additional information.

If a new patient receives both medical and mental healthcare on the same day, the patient is only considered new for one of these visits.

Range Health follows Medicare guidelines regarding the billing requirements and proper coding for services provided to Range Health MA, members. CMS offers Frequently Asked Questions (FAQs) regarding RHC billing requirements. Refer to the CMS website for additional information.

Policy History

Date	Action	Reason

Changes in Member Status

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to delete or modify this policy in accordance with our provider contracts.

Policy

Please notify us if a member's status change is a result of:

- End-stage renal disease (ESRD)
- Changing residence to an institution
- Hospice care
- Notification of permanent move out of Medicare Advantage plan service area

If you become aware of a Medicare Advantage member for whom one of the above applies, please notify Medicare Advantage Customer Service. This notification will help us assure the member receives appropriate benefits and the Centers for Medicare and Medicaid Services (CMS) is notified of the member's change.

Policy History

Date	Action	Reason

Changes in Practice

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Contracting providers must notify Range Health in writing via email, fax, or USPS mail of any following practice changes:

- **Change in ownership or tax identification number,** (please include a copy of the updated W-9).
    - Let us know if claims with dates of service prior to the tax identification change fall under a previous tax identification number so we can issue new provider numbers.
    - If your tax identification change represents a change of ownership, your contracts with Range Health may not be valid. Please contact Provider Relations prior to ownership changes to ensure your contracting status remains in place.
- Change of address or additional service location.
- Change in office hours.
- **Change in providers who join or leave their practice.**
- Change in physicians accepting new members status.
- Change in sponsoring/supervising physician if you are a nurse practitioner, physician assistant or service extender working under the supervision/sponsorship of a physician.
- Licensing restrictions.
- Program exclusions or preclusions.
- Medicare Opt-out.

- Criminal convictions relevant to continuing to provide patient care under terms of the provider agreement(s) with Range Health.

If it is determined that a provider has not provided updates, Range Health retains the right to suppress providers from the directory until timely updates are received. Providers are asked to submit practice changes at least 30 days in advance.

- Contact Provider Relations at providerrelations@rangehealth.com to determine the paperwork you will need.

Primary care physicians (PCPs) must continue accepting new patients until Range Health receives 30-day written notification indicating they will not accept, or will limit acceptance of new patients.

Policy History

Date	Action	Reason

Chiropractic Services

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Covered Services

Coverage of chiropractic services is limited to manual manipulation (by use of the hands) of the spine for correcting a subluxation for acute or chronic active/corrective treatment.

- Subluxation is defined as a motion segment in which alignment; movement integrity and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

Chiropractors may use manual devices (those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine. Range Health Medicare Advantage plans do not recognize an extra charge for the device itself or allow an additional payment for the use of these devices.

Range Health will process claims for active/corrective treatment submitted with CPT codes 98940, 98941, 98942 or 98943. Each claim line should include the active treatment modifier (AT in the primary position, the claim will deny as maintenance therapy.

Non-covered Services

Other than the manual manipulation described above, diagnostic or therapeutic services, furnished by a chiropractor, or provided under his/her order, are not covered. This means that if a chiropractor orders, takes or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test can be used to demonstrate subluxation, but Medicare Advantage coverage and reimbursement are not available for those services.

Maintenance therapy is ***not*** a covered benefit under Medicare Advantage Plans.

- Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy to stabilize a chronic condition or prevent deterioration.

Claim Submission

Claims for chiropractic services should follow current Medicare guidelines including, but not limited to, the use of appropriate procedure codes, modifiers, and diagnosis codes.

Policy History

Date	Action	Reason

Claim Changes from Inpatient to Outpatient Observation

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, modify this policy in accordance with our provider contracts.

Policy

Most facilities submit inpatient claims based upon the attending physician's written orders. Range Health may deny payment for inpatient admission services not demonstrating medical necessity. Inpatient claims not supported by clinical criteria are eligible for reconsideration under outpatient reimbursement when resubmitted as a new claim for observation or outpatient services.

Use the following steps when resubmitting a claim for observation or outpatient services:

1. Indicate outpatient type of bill 13x
2. Do not include revenue codes for room and bed charges
3. Include charges for observation hours under revenue code 76x
4. Include ancillary charges omitted from the original inpatient claim
5. Include HCPCS/CPT codes on outpatient claim

Submit corrected claims electronically to Range Health.

Policy History

Date	Action	Reason

Claim Submission/Payment

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Claims submitted to Range Health Medicare Advantage plans should use current Medicare billing guidelines and approved forms. Regardless of the format used, all submitted claims are required to contain complete and accurate information relevant to claim processing including:

- Member name
- Provider name, address and identification number
- Available information regarding third-party liability and other applicable underwriting or insurance coverage
- Relevant occurrence date
- Itemization of charges, date of service, principal diagnosis and procedure codes, and, if appropriate, secondary diagnoses and procedures utilizing a standard coding system acceptable to Medicare Advantage plans

By submitting claims with the above information, Range Health can expedite processing and payment of claims, and prevent the return of claims for required processing information.

The claims department will pay clean claims within 30 days.

Medicare Advantage must receive claims no later than 12 months from the date of service or as specified in the provider's contract. Range Health does not accept CMS 1500 paper claims.

We make organizational determinations (including denials and payments) on all claims within 60 days of receipt.

When a member has health insurance coverage under two or more plans, and Medicare Advantage is the secondary payer, attach evidence of the primary payer’s payment to the

claim. The claim will not be processed until the primary payment information is received. The combined payments by the plans will not exceed the Medicare Advantage allowable.

Medicare Advantage follows Medicare guidelines to identify a primary insurance carrier.

Policy History

Date	Action	Reason

Claims Encounter Data Language

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

A participating provider recognizes that Range Health is responsible for verifying the completeness and accuracy of all claims encounter data. Range Health will report encounter data to Centers for Medicare and Medicaid Services (CMS) in a timely manner, as required by CMS.

Policy History

Date	Action	Reason

Clinical Trials

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health Medicare Advantage Plan members receive the same coverage for clinical trials as a person in an Original Medicare plan. Important factors providers need to understand include:

Benefits:

- The clinical trial must be a qualifying Medicare clinical trial.
- No prior authorization is required; however, members are encouraged to notify Range Health to keep track of health care services.

Reimbursement:

- Medicare carriers and intermediaries will pay providers for clinical trial services furnished to Range Health Medicare Advantage members.
- For claims with a Medicare Summary Notice (MSN)/ Explanation of Benefits (EOB), Range Health pays the member the difference between Original Medicare cost-sharing for qualified clinical trial items and services. This cost-sharing reduction requirement applies to all qualifying clinical trials. We are not able to choose the clinical trials or items and services to which this policy applies. Range Health owes this difference even if the member has yet to pay the clinical trial provider. Additionally, we must include the member's in-network cost-sharing portion to their out-of-pocket maximum calculation. We require claims for services related to a clinical trial to include modifier Q0 or Q1 for each HCPCS code related to the trial.
- If we receive a claim with lines containing modifier Q0 or Q1, but no accompanying MSN/EOB, Range Health will process the claim indicating member responsibility for the Original Medicare cost-sharing and include a remark that the member must submit the MSN/EOB for correct cost-sharing reductions.

Routine covered costs of clinical trials-defined by Medicare:

- Included are items or services typically identified as covered medical services according to the member's Benefit Summary and/or the member's Evidence of Coverage (EOC). For coverage consideration services must fall into the Medicare covered benefit category.

Non-covered costs of clinical trials according to Medicare:

- Routine costs of qualified clinical trials do not include the cost of investigational items of service, items and services for which there is no Medicare benefit, statutorily excluded items, or items and services that fall under a national no coverage policy. These items and services are the member's responsibility unless otherwise arranged.

Resources:

- National Library of Medicine http://clinicaltrials.gov/ for government and private studies across the country.
- National Cancer Institute, Cancer Information Service provides cancer information and help in locating cancer trials: (800) 422-6237

Policy History

Date	Action	Reason

Code of Ethical Business Conduct

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The Code of Ethical Business Conduct (the Code) serves as a formal statement of our commitment to ensure business is conducted with integrity, and adherence to the highest ethical business practices. The Code is the foundation of the Corporate Compliance Program. The Code, as well as supporting corporate policies, set the standards of conduct to ensure everyone at the Company understands what is expected of them in terms of business, professional, legal and personal ethics. All employees are responsible to: comply with applicable rules, laws, and regulations; conduct themselves in an ethical manner; report issues of non-compliance and potential fraud, waste and abuse (FWA) through appropriate mechanisms; address and correct reported issues; and be responsible for compliance from the top to the bottom of the organization.

The Code is available online to all employees upon hire as well as available to Range Health vendors and members of the public. Annually, employees are also required to complete a Conflict of Interest Disclosure and acknowledge they have received, read, and will comply with the Code. Non-employee members of the Board of Directors review proposed changes to the Code before any updates are finalized.

Applicability

Range Health expects our directors, corporate officers, employees, and third-party entities to act in an ethical manner and comply with applicable laws and regulations. We encourage third-party entities to adopt and follow a Code of Conduct specific to their own organization to reflect a commitment to detecting, preventing, and correcting non-compliance and fraud, waste and abuse in the administration and delivery of Range Health products, including Medicare Advantage (Part C) and Medicare Advantage Prescription Drug Plan (Part D) benefits.

Reporting Violations

Employees also have a duty to report actual, suspected, or potential violations of applicable rules, laws, regulations, and Company policies, as well as to cooperate with any internal investigations. The Company provides employees with a mechanism for anonymous reporting of actual, suspected, or potential violations. Even if a report or complaint is not made anonymously, Range Health will maintain the confidentiality of the employee's identity during the investigation process to the extent possible under the applicable law, and within the practicalities of the situation. Retaliation or intimidation against anyone who makes a good faith report of an actual, suspected or potential violation is strictly prohibited.

Policy History

Date	Action	Reason

Confidentiality of Member Records

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

It is the provider`s responsibility to safeguard all records and confidential information against any alteration or disclosure prohibited by state and federal law.

The provider shall maintain the records and information in an accurate and timely manner.

The provider shall ensure timely access by members to the records and information that pertain to them.

When requesting prior authorization of services, provider shall give necessary information to the provider to whom the service is authorized. This information includes, but is not limited to clinical summaries, history and physicals, and diagnostic work-ups.

When rendering services as directed by a Primary Care Provider (PCP) or other physician, the servicing provider shall submit a report of findings or treatments rendered to the referring provider.

The provider shall request, and be given, information from other screening providers regarding treatments rendered as necessary to provide care.

Upon receiving a signed records transfer form, provider shall facilitate the transfer of a member’s medical records to the new provider. All appropriate medical records must be transferred to a member’s new PCP in a timely manner to ensure continuity of care.

Policy History

Date	Action	Reason

Cost Share Refunds

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health is required to ensure that members are not held financially responsible for anything outside their benefit coverage per Code of Federal Regulations 42 CFR 422.70 (b). If a provider mistakenly collects more than the designated cost share amount from the member, or when a claim is reprocessed and patient liability is impacted, we rely on our providers to refund any previously collected cost share, and only bill patients for those dollars that are reflected as deductibles, copayments, coinsurance or non-covered amounts. To ensure compliance, we will conduct quarterly audits of reprocessed claims that removed or reduced member cost share. Each quarter, we will perform a retrospective review of claims reprocessed from the previous three months and will outreach to providers on a sampling of claims where member liability has been removed or reduced

If your office is contacted, you will be asked to provide verbal confirmation that the patient has been issued a refund of any previously collected dollars that are no longer member responsibility.

If you have not refunded the patient for any dollars that are not his/her responsibility, a case may be opened with our Special Investigations Unit.

Policy History

Date	Action	Reason

Credentialing Appeal Rights

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information i to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

If a provider fails to meet the credentialing/recredentialing standards at any time, the Credentialing Committee may take action to deny, terminate, suspend credentialing or sanction the provider. Such actions may be appealed to a panel of practitioners selected by the Credentialing Committee, as provided in this policy. The provider can be a person or facility.

Procedures for Action by Credentials Committee

1. If a provider fails to meet the standards and criteria for credentialing or recredentialing, the Credentialing Committee may act to deny, terminate, suspend credentialing, or sanction the provider. The Credentialing Committee shall make reasonable efforts to obtain facts relevant to its determination prior to taking action.
2. In cases where the Chief Medical Officer or his/her designee and/or Credentialing Committee determines that the circumstances may pose an immediate danger to the health or safety of members, a provider may be suspended or terminated from the network immediately, subject to subsequent notice and hearing or other adequate procedures.
3. The Credentialing Committee shall notify a provider in writing within 30 days of a decision to deny, terminate, suspend credentialing or sanction the provider. Such notification will outline:
    - The decision;
    - the reason(s) for the decision, including facts upon which the decision is based; and
    - appeal rights, if applicable.

4. The Credentialing Committee will report all actions against a provider based on the provider's professional competence or conduct to the National Practitioner Data Bank. Issues are not reported until after any applicable appeal rights have been exhausted and a final decision has been made.

Appeals Procedure

1. A provider may appeal a decision of the Credentialing Committee to deny, sanction, suspend, or terminate credentialing by submitting a written appeal and any additional information the provider would like to include for consideration to the Chief Medical Officer within 30 days of receipt of the Credentialing Committee's decision to deny, sanction or terminate credentialing.
2. The Credentialing Committee shall have the right to reconsider its decision by notifying the provider of its intent to do so, and requesting additional information, if necessary, within 30 days of the Chief Medical Officer's receipt of the appeal. The provider shall receive written notice of the Credentialing Committee's decision upon reconsideration within 30 days of its receipt of additional information. If the Credentialing Committee upholds its prior decision, the provider will receive written notice of the decision, the reasons for the decision, the facts upon which the decision is based, and appeal rights, including the right to request an appeal hearing. If the Credentialing Committee declines reconsideration, the provider will receive notification of additional appeal rights, including the right to request a hearing. The provider may request an appeal in writing by acknowledging he/she voluntarily waives his/her right to a hearing.
3. Upon timely receipt of a written appeal and request for hearing, the Chief Medical Officer shall appoint an appeal panel of at least three practitioners who are not in direct economic competition with the provider and designate one of them the committee chair. One panelist shall be a Range Health Medical Director who has not previously been involved in the case and one panelist shall be of the same clinical specialty as the appellant. The Chief Medical Officer who appoints the appeals panel may also appoint a hearing officer to preside over the hearing. The hearing officer will not take part in the appeal panel's deliberations, but will direct the proceedings.
4. The committee chair, or the hearing officer, if one is selected, shall notify the provider of the hearing's time, place and date. The hearing shall be scheduled on a date no sooner than 30 days after the date appearing on the notification of hearing.
5. The notice of hearing shall state:
    - The place, time and date of the appeal hearing, and the date shall not be less than 30 days after the date of notice of hearing;
    - the practitioners who will constitute the appeal panel;
    - a list of the witnesses, if any, expected to testify at the hearing on behalf of Range Health;
    - that the provider has the right to representation by an attorney or other person of choice at his/her expense;

- that the provider has the right to have a record made of the proceedings, copies of which may be obtained by the requesting party upon payment of any reasonable charges associated with the preparation thereof;
- that the provider has the right to call, examine, and cross-examine witnesses;
- that the provider has the right to present evidence determined to be relevant by the panel, regardless of its admissibility in a court of law;
- that the provider has the right to submit a written statement at the close of the hearing; and
- that the provider shall receive a written decision after the hearing.

6. Within 10 days after the provider has received the hearing notice, the provider may deliver to the committee chair, or hearing officer, if one is appointed, a written challenge to the impartiality of any appeal panel members for demonstrated bias or direct economic competition and for no other cause.

   Within 10 days of receipt of the challenge, the committee chair or hearing officer shall notify all parties in writing of the decision regarding the challenge. The notification, which must be no more than 30 days from the original hearing date, will include the basis for the challenge, the names of the replacements, if any, and the rescheduling of the hearing date, if required, to accommodate new panel members.
7. At least 10 days prior to the hearing, the provider shall provide the committee chair or hearing officer a list of witnesses, if any, expected to testify at the appeal hearing on behalf of the provider.
8. The provider may forfeit the right to the hearing if the provider fails, without good cause, to appear.
9. Within 15 days after final adjournment of the hearing, the appeal panel shall prepare and send to the provider and the Chief Medical Officer, a written decision that includes findings of fact and explaining its conclusions regarding the issues at the hearing.
10. The appeal panel's decision shall be final and binding on all parties.

References

42 CFR 422.202, 42 CFR 422.204, 64 FR 7968, 42 CFR 1395w-22; 42 U.S.C. § 11112

Policy History

Date	Action	Reason

Credentialing/Recredentialing Standards for Facilities

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information i to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The goal of our credentialing/recredentialing program is to:

- Ensure high-quality facilities for members
- Provide an optimal number and distribution of facilities
- Minimize health and safety risks for members

To begin the credentialing process, each facility submits an application. A credentialing specialist performs the primary source verification as applicable.. Facility information is verified at least every three years for credentials committee review. The credentials committee consists of the Range Health medical director and physicians with various specialties from around the state

Range Health's credentialing/recredentialing standards include criteria that all healthcare facilities must meet (as applicable) and maintain. Healthcare facilities must uphold these standards to be accepted, or to continue, as Range Health network providers. The credentials committee applies the standards listed below when making credentialing decisions.

Application, Attestation and Release

Information provided on a facility's application cannot be more than 180 days old at the time of review. All sections of the application must have complete answers or explanations. Facilities may attach documents, but Range Health does not consider attachments as a substitution for a complete application. As applicable, the facility must attach current copies of its license, Board of Pharmacy license, certificate of insurance for professional liability, certificate of insurance for worker's compensation, certification, most recent Medicare survey, accreditation, quality program description, ownership documentation and a list of practicing physicians and other healthcare providers. The facility must sign and date an unaltered attestation and release.

License (initial, recredentialing, and ongoing)

The facility must maintain a current license in good standing from the appropriate state licensing agency (if applicable) that is not revoked, terminated, expired, restricted, suspended, imposed with conditions, stipulations, disciplinary actions, probation or otherwise modified in any way at the time of credentials committee review.

Board of Pharmacy License (if applicable)

Verification of a valid current certification at initial credentialing and recredentialing is required.

Certification

Verification of certification and a copy of the most recent Medicare survey, conducted within three years of the credentials committee review, is required if applicable for your facility type. If a current survey is not available, the credentials committee may require a site survey by Range Health personnel. For laboratories, a copy of the Clinical Laboratory Improvement Amendments (CLIA) certificate is required and must be current at the time of credentials committee review.

Accreditation (as applicable):

Verification of accreditation is required if a facility indicates that it is accredited. Ambulatory Surgery Centers (ASC) are required to be accredited by AAAHC, AAASF, or JCAHO. Medicare certification for ASC's does not meet this standard.

Malpractice Insurance:

Coverage amounts must be at least $1,000,000 per incident; $3,000,000 aggregate or unlimited aggregate. Insurance must be current at the time of credentials committee review.

Worker's Compensation Insurance:

Coverage is required and must be current at the time of credentials committee review.

Medicare Participation:

Facility shall be participating with Medicare if applying for a Medicare Advantage contract. Medicare participation is required for all facilities with more than 50 beds.

Medicare/Medicaid Sanctions, Federal Exclusions or Fraud (internal or external information, initial, recredentialing and ongoing)

The facility must not have any sanctions, federal exclusions, or evidence of fraud.

Quality Management, Patient Safety Programs, Structure and Policies:

Facility shall have quality management and/or patient safety programs in place at the time of credentials committee review. Facility shall provide Range Health a description of these programs and make the full program documentation available upon request. Facility is required to demonstrate administrative structure and policies to support that structure.

Materials describing the organization:

Facility shall attach materials describing the facility and its ownership to the application.

Transfer Agreements:

ASC's and Skilled Nursing Facilities are required to have a transfer agreement with an acute care hospital. Verification will be a signed agreement by the hospital. If a transfer agreement is not in place, the facility is required to provide documentation of local hospital privileges for medical staff.

Range of Services:

Facility will provide access to an appropriate range of services for the service area.

Policy History

Date	Action	Reason

Credentialing/Recredentialing Standards for Practitioners

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Credentialing is a review of qualifications and other relevant information pertaining to a health care professional who seeks a contract with Range Health. Credentialing is required for physicians and health care professionals who provide services to members and who are permitted to practice independently under state law. Per industry standard guidelines, credentialing is also required for practitioners who have an independent relationship with Range Health.

Credentialing is not required for health care professionals who are permitted to furnish services only under the direct supervision of another practitioner or hospital-based health care professionals who provide services incident to hospital services (unless those health care professionals are separately identified in literature such as the provider directory as contracted).

The goal of our credentialing/recredentialing program is to:

- Ensure high-quality providers for members
- Provide an optimal number and distribution of providers
- Minimize health and safety risks for members
- Minimize legal risks

To begin the credentialing process, each physician or healthcare professional submits the most recent version of the credentialing application. A credentialing specialist performs the primary source verifications and review. Practitioners must meet credentialing standards and criteria and be approved by the Credentialing Committee at least every 36 months. The Credentialing Committee consists of a Range Health Medical Director and a variety of practitioners of various specialties, facility administrators, and behavioral health professionals.

Range Health's credentialing/recredentialing standards are criteria that all healthcare professionals must meet (as applicable) and maintain. Healthcare professionals must uphold these standards to be accepted, or continue, as network providers. The Credentialing Committee applies the following standards when making credentialing decisions:

Application, Attestation and Release

Information on a practitioner's application cannot be more than 120 days old at the time of review. All sections of the application must have complete answers or explanations. Practitioners may attach curriculum vitae, but it is not considered a substitute for completing the application. The practitioner must attach current copies of his/her license, DEA registration/DEA waiver, certification, certificate of insurance for professional liability, and Educational Commission for Foreign Medical Graduates certificate, if a foreign graduate, to his/her application. The practitioner must complete, sign, and date an unaltered attestation and release.

License (initial, recredentialing, and ongoing):

The practitioner must have a current license in good standing from the appropriate primary practice state licensing agency. The license cannot be revoked, terminated, expired, restricted, suspended, imposed with conditions, stipulations, disciplinary actions, probation or otherwise modified in any way at the initial Credentialing Committee review or the recredentialing review.

Drug Enforcement Agency (DEA) Certificate (initial, recredentialing, and ongoing):

- No DEA revocation allowed.
- Verification of a valid current certification at initial credentialing and recredentialing is required.
- DEA Waiver (as applicable)

Board Certification and Education (MDs and DOs):

- Board certification is not required.
- A completed residency in that specialty is required for physicians listed as specialists.
- Listings for physicians that are board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) are sometimes separate from residency trained, non-board certified physicians.
- Physicians listed as "General Practice" in the provider directory are not ABMS or AOA certified or have not completed a residency but are medical school graduates and completed an internship.

Certification and Education (all other practitioners as applicable):

Verification of certification is required if a practitioner indicates that he/she is certified. The institution granting the degree or the state licensing agency can verify completion of education if they perform primary source verification.

Work History:

Practitioners cannot have unexplained lapses in work history for the previous five years. Practitioners may be required to explain gaps in work and education history beyond the previous five years or greater than six months.

Malpractice Insurance:

- Coverage amounts must be at least $1,000,000 per incident; $3,000,000 aggregate or unlimited aggregate.
- Insurance must be current at the time of Credentialing Committee review or at time of practitioner's stat date.

Malpractice History, Professional Liability Claims History, Civil Judgments, Federal/State Criminal Convictions, Adverse Actions:

- The Credentialing Committee grants acceptance into the Range Health network if they determine the pattern of litigation, conviction(s), civil judgment(s), or adverse action(s) is not predictive of significant patient risk in the future.
- The Credentialing Committee does not review malpractice cases that occurred during internship or residency.
- The Credentialing Committee will review two or more open cases; single closed cases over $500,000; two or more closed cases over $25,000; all adverse actions, civil judgments and convictions.
- The Credentials Committee will review all adverse actions, civil judgements and convictions within the past ten years.

Twenty-four Hour Coverage:

- All managed care physicians must have 24-hour coverage by themselves or with an on-call arrangement.
- Referral to the local emergency room is not acceptable.

Provider Impairment:

The practitioner must not have any physical or mental impairment that prevents adequate patient care.

Alcohol or Drug Abuse:

The practitioner must not have any evidence of ongoing substance abuse.

Felony Conviction:

The practitioner must not have any felony convictions or guilty pleas.

Medicare/Medicaid Sanctions, Preclusions, Federal Exclusions or Fraud (internal or external information, initial, recredentialing and ongoing):

The practitioner must not have any sanctions, preclusions, federal exclusions, or evidence of fraud.

Medical Record Review:

The Range Health Quality Department reviews medical records in accordance with quality management policies and procedures.

Office Site Review:

Range Health assess sites that meet Range Health thresholds for grievance/complaints.

Site visits are required at initial credentialing for any practitioner who meets the compliant thresholds.

Office Site must pass the site review as indicated on the site review tool.

Quality Concerns:

Our quality management department investigates, monitors, and tracks quality concerns and forwards reports to the Credentialing Committee as indicated in the quality management policies and procedures. The Credentialing Committee will review the quality report and use its judgment in determining a course of action.

Utilization Management (recredentialing):

The quality management department reviews utilization management. Utilization management information goes to the Credentialing Committee as indicated in the quality management policies and procedures.

Addictive Drug Prescribing Habits:

The Credentialing Committee reviews the practitioner's history and restrictions on prescribing habits from the applicable Board of Medical Examiners to determine whether the practitioner's history and prescribing habits as restricted, pose unacceptable patient risk.

State Disciplinary Board:

The Credentialing Committee reviews disciplinary board actions or ongoing sanctions to determine if the behavior poses an unacceptable risk to patients. State disciplinary board actions for the past ten years are reviewed.

Sexual Misconduct:

No Sexual Exploitation by a Medical Care Provider, as defined by the licensing state's Administrative Code. All providers, regardless of primary practice state are required to meet this standard.

Eligibility:

- The practitioner's practice must represent his or her specialty training.
- Credentialed practitioners may be listed in the directory as either:
    - Primary care practitioners with a specialty in family practice, internal medicine, obstetrics and gynecology, pediatrics, or a general practice that provides comprehensive care to Range Health members.
    - Non-primary care practitioners who have training in a specialty approved by the ABMS, AOA or Board of Nursing, that do not wish to have patients assigned to them because their practice is referral/specialty based.

Range Health's credentialing/recredentialing standards are criteria that all healthcare professionals must meet (as applicable) and maintain. Healthcare professionals must uphold these

Policy History

Date	Action	Reason

Data Accuracy

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

For the purposes of data accuracy, Range Health considers a standard claim form UB-04 or CMS-1500 to be a primary source document. Any attached documentation should be consistent with the information on the claim form. In the event of inconsistencies, Range Health will make a reimbursement based on the data found on a primary source document. At the discretion of Range Health, claims with inconsistencies may require additional investigation or be returned for correction.

When submitting claims data, providers must ensure the data is true and accurate to the best of their knowledge and belief.

Policy History

Date	Action	Reason

Direct Correspondence with Medicare Advantage Plan Member

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information i to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The Centers for Medicare and Medicaid Services (CMS) has specific guidelines for written communication with current and prospective Medicare Advantage plan participants. In many cases, they require the use of CMS generated model language. These guidelines apply not only to Range Health, but also to providers who send written communication to their patients referencing Range Health and any of our Medicare Advantage plans.

CMS considers any provider materials that mention Range Health or any of our Medicare Advantage plans as marketing material. Therefore, these items must adhere to the guidelines set forth in Chapter 3 of the *Medicare Managed Care Manual, Medicare Marketing Guidelines.* These materials also require Range Health and CMS approval prior to distribution.

Send provider-generated materials referencing Range Health for review to:

- Range Health
  Attn: **Provider Relations**
  PO Box 8406
  Boise, ID 83707

Provider Relations will review and forward your request to Range Health's Medicare Advantage marketing specialist for review and CMS submission. We will notify you when the review is complete and if your material is approved or denied for distribution.

Policy History

Date	Action	Reason

DME Capped Rental

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The CMS DMEPOS fee schedule identifies capped rental items as category CR. After 13 months of rental, a beneficiary owns the capped rental DME item and Range Health pays for reasonable and necessary repairs and servicing of the item (i.e., parts and labor not covered by a supplier's or manufacturer's warranty).

CAPPED DME RENTAL SUPPLIES MAY INCLUDE:

Commode chair	Wheelchair including power, and accessories
Pressure ulcer equipment	Patient lift
Bilirubin light	Defibrillator
Paraffin bath	Negative pressure wound pump
Bed, bedrails, safety frame for bed	Traction equipment
Mattress	Nebulizer
Apnea monitor	Respiratory device

CAPPED DME MODIFIERS MAY INCLUDE:

KH - DMEPOS item, initial claim, purchase or first month rental

KI - DMEPOS item, second or third month rental

KJ - DMEPOS item, rental four to 13 months

Please note that there are two separate payment methodologies for power-driven wheelchairs and for all other Capped DME supplies.

Power-driven wheelchairs - The total rental payments equal 105 percent of the purchase price.

Month	1	2	3	4	5	6	7	8	9	10	11	12	13
KH	15%												
KI		15%	15%										
KJ				6%	6%	6%	6%	6%	6%	6%	6%	6%	6%

All other capped DME supplies - The total rental payments equal 105 percent of the purchase price.

Month	1	2	3	4	5	6	7	8	9	10	11	12	13
KH	10%												
KI		10%	10%										
KJ				7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%

Pricing: If the RR modifier is present, but without the KH, KI or KJ capped rental modifiers, we will return the claim for a corrected bill.

REPAIR AND REPLACEMENT:
Replacement items and repairs require prior authorization after satisfying the eligibility timeline requirements.

1. With the exception of supply code K0739, repairs are not allowed during the rental period. Range Health Medical Management requires prior authorization of code K0739. No replacement is allowed prior to five years from the date of purchase.
2. Use Modifier RA to report loss, irreparable damage, or a stolen item. Use Modifier RB for replacement parts furnished i to repair member owned DME.

   RA - Replacement of a DME item
   RB - Replacement of a part of DME furnished as part of a repair

DME Rental Item -Partial Month

KR modifier is used for a rental item billing for a partial month. This modifier is used by suppliers who determine that services were only supplied for a partial month.

If Range Health discovers that a member's equipment is supplied for a partial month, we reserve the right to prorate the service and allow the number of days the equipment was used by the member.

Note: *Range Health's Special Investigation Unit may perform post audit review to monitor provider billing for appropriate use of Capped Rental modifiers.*

Policy History

Date	Action	Reason

Emergency and Urgent Services

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Emergency Services

We do not require prior authorization for emergency medical treatment. Range Health Medicare Advantage plans cover emergency services whether the member is in or out of their plan's service area. We define emergency services as covered inpatient or outpatient services that are:

- Furnished by a provider qualified to furnish emergency services.
- Needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is one with acute symptoms severe enough (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the lack of immediate medical attention to result in:

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

Urgently needed care within the plan's service area:

Urgently needed care is care needed immediately for an unforeseen illness or injury that is not unreasonable, given the situation, to receive medical care from the member's Primary Care Physician (PCP) or other plan providers. In this case, the member's health is not in serious danger. If the member has a sudden illness or injury that is not a medical emergency and the member is in the plan's service area, the member should call his or her PCP.

Urgently needed care outside the plan's service area:

When members are outside the plan's service area, Medicare Advantage covers urgently needed care provided by non-participating providers. Whenever possible, members should first contact their PCP for urgent care when they are outside the plan's service area. Members should also receive follow-up care from their PCP for any treatment received outside the service area. When a member receives care that meets the definition of urgently needed care from non-participating providers outside the plan service, we cover claims for any follow-up care needed.

When one of the following is present on a claim, it will be identified as an urgently needed care claim:

- **Place of Service 20:** When billing for urgently needed care services on a CMS-1500, urgently needed care is determined by the place of service 20 (urgent care) regardless of the diagnosis billed for the E & M code.
- **Revenue code 456:** When billing for urgently needed care services on a UB 04, urgently needed care is determined by the Rev Code 456 regardless of the diagnosis billed.
- **Revenue Code 516:** For rural health clinics or other UB04 clinic billing, urgently needed care is determined by revenue code 516.

Policy History

Date	Action	Reason

HEDIS® Audit

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The Healthcare Effectiveness and Data Information Set (HEDIS®) measures performance in healthcare where improvements can make a meaningful difference in people's lives. HEDIS allows health plans to identify quality improvement opportunities to improve the health of members and communities.

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage Organizations (MAO) to participate in the annual HEDIS audit. According to section 1852(e) of the Social Security Act, CMS has the authority to collect quality data to establish a 5 Star rating for MAO's. The 5 Star rating allows members to compare quality amongst health plans in their area. Data collected is submitted to the National Committee for Quality Assurance (NCQA) and CMS.

Range Health requests all contracted providers participate in HEDIS by sending medical records to close HEDIS quality gaps in care. Range Health will send medical record requests, at no cost to Range Health and/or its members, to participating providers January through May to close gaps in care as part of the annual regulatory audit. Range Health may request records, at no cost to Range Health and/or its members, periodically throughout the remainder of the year to support quality improvement initiatives. Participation in HEDIS demonstrates a practice's commitment to quality and improved outcomes for our mutual members.

The staff at Range Health will only request records for members who have an open gap in care associated with a specific HEDIS measure. When Range Health is granted access, the Quality Management team will dedicate resources to extract records from your EHR, reducing the burden on the practice. Due to the timeline of the HEDIS audit, it is unlikely that Range Health can dedicate staff to come to your office to abstract records.

Policy History

Date	Action	Reason

Hospital Outpatient Observation

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete. or modify this policy in accordance with our provider contracts.

Policy

Hospitals provide observation services on their premises. These services include the use of a bed and periodic monitoring by hospital nursing staff or other staff members. They must be reasonable and necessary services used to evaluate a patient's condition, or to determine the need for a possible inpatient admission.

Based on review of clinical documentation and evidence-based guidelines, Range Health's Medicare Advantage Care Coordination department determines the appropriateness of observation services, or if the patient is better served through an inpatient admission.

Observation services are a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment. These services are furnished while a decision is being made regarding a patient's need for further inpatient treatment, or if the patient can be discharged from the hospital.

CMS requires members receive prompt written notification when an inpatient stay is not medically necessary and is reclassified as an outpatient observation. This written notification is necessary to keep the member fully informed about how a change in status affects their cost sharing (coinsurance and deductible) responsibilities.

Provisions of the NOTICE Act require hospitals and critical access hospitals to deliver the Medicare Outpatient Observation Notice (MOON) to a beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours.

For outpatient claims submitted on UB-04 claim form, we require HCPCS/CPT-4 codes in field 44 for revenue codes of 0510-0520 and 0761-0769. We will process claim lines without a HCPCS/CPT code as a contractual adjustment.

Please submit outpatient observation claims as bill type 013X.

Policy History

Date	Action	Reason

Identifying Members Who Require Care Management

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

High-risk conditions or situations that may require care management:

- Aggregate claims of greater than $50,000 per year
- AIDS or HIV related conditions
- Burns greater than or equal to 20 percent of body area
- Cancer with intensive treatment and/or special needs
- Cerebrovascular accident with sequelae with continued functional impairment
- Changes in Primary Care Physician (PCP) three or more times in one year if for other reasons than network changes
- Chronic renal failure/ESRD
- COPD with two or more hospital admissions within last year
- Diabetes mellitus with complications such as labile blood glucose, open wounds, nephropathy, retinopathy, or neuropathy that puts patient as risk for further complications or lifestyle changes
- End-of-life issues
- Frequent use of emergency room (four or more visits in last year)
- Greater than one hospitalization within the past three months
- High-risk pregnancy
- Multiple chronic and acute conditions identified through reports and referrals
- Multi-system health problems (three or more co-morbidities)
- Neuromuscular disorders (i.e., multiple sclerosis, muscular dystrophy, ALS, myasthenia gravis, cerebral palsy) with rapidly deteriorating status or exacerbation that put the patient at risk for lifestyle changes
- Organ transplants

- Prolonged inpatient stay
- Repeated acute hospital admissions (three or more admissions in last year)
- Trauma wounds at level three or four or several lesser wounds; wound orders include sharp or chemical debridement; an inpatient wound program has been ordered by the treating wound specialist
- Multiple providers
- Psychosocial issues

Policy History

Date	Action	Reason

Incomplete Provider Contracts

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health works on behalf of our members to develop contracting relationships with healthcare providers. We have specific contract criteria established for all provider specialties to ensure that our contracting providers meet acceptable provider licensing, accreditation, and/or medical standards to provide the highest quality of care and services.

To expedite our contracting process, we ask that providers provide all necessary contract enrollment information on the *initial* submission including credentialing applications where applicable. Incomplete information will delay the contract implementation process.

Range Health implements **completed** provider contracts following the completion of the credentialing process. We ask providers for missing or incomplete information up to three times and document each contact attempt. We then retain incomplete provider enrollment packets and/or contract for a period of ninety days. After ninety days, Range Health includes a record of the documentation requests in the provider file and destroys the incomplete contract.

Below are common reasons for provider contract processing delays.

Missing Information

- Credentialing application
- Provider license (i.e., physician, lab, DME)
- Accreditation certificate
- Proof of liability/professional insurance
- Medicare number
- CLIA certificate
- NPI provider identification
- Tax identification number or W-9
- Surety bond for DMEPOS providers

- Provider information sheet (PIS)

Incomplete Information

- Incomplete credentialing application or supporting documentation
- Incomplete attachments
- Unsigned contract
- Clinic name inconsistencies throughout the contract
- Unauthorized signature on contract
- Invalid provider for type of contract
- Current contract version

Send provider contract information to:

Email: providerdata@rangehealth.com

Policy History

Date	Action	Reason

Locum Tenens

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, orise modify this policy in accordance with our provider contracts.

Policy

When a provider is on medical leave or vacation, a locum tenens provider can be identified and authorized to treat patients during the time the primary provider is out of the office.

Requirements and Process

- The provider using a locum tenens must be a participating provider with Range Health with an "active" status. Claims submitted in the name of a provider no longer working at the clinic or office will not be accepted.
- Claims for services rendered by a locum tenens are submitted under the authorizing physician's name, National Provider Identifier (NPI) and Tax Identification Number (TIN). Modifier Q5 or Q6 must be appended to each procedure code, signifying that the service was rendered by a locum tenens provider.
- The locum tenens must be the same type of provider as the authorizing provider (for instance: an MD can only authorize another MD or DO as a locum tenens, a DC can only authorize another DC, an ARNP can only authorize another ARNP, etc.). To be considered for locum tenens status, the temporary provider must be one of the following provider types:
    - Doctor of Medicine (MD)
    - Physician Assistant (PA)
    - Doctor of Dental Surgery (DDS) *
    - Doctor of Dental Medicine (DMD) *
    - Doctor of Podiatry (DPM)
    - Doctor of Optometry (OD)
    - Doctor of Osteopathy (DO)
    - Doctor of Chiropractic (DC)
    - Doctor of Naturopathy (ND)

    - Nurse Practitioner (NP)
    - Physical Therapists (PT)
- The locum tenens must be licensed in their state (as applicable based on practice location) and only perform services within their scope of license.
    - Locum tenens do not require credentialing by Range Health
- The use of a locum tenens provider by a participating provider is limited to **60 days per 12-month period**. However, Range Health may, under certain circumstances, make an exception.
    - Exceptions must be submitted to provider relations at providerrelations@rangehealth.com with request for exceptions.

* Medical claims only.

Policy History

Date	Action	Reason

Maximum Daily Frequency Edits

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Certain procedures are billable only once per day.

If Range Health receives a claim with units exceeding the maximum daily frequency, we will reduce the claim allowance to an equivalent of one unit based on the charge amount.

You can find the list of CMS Medically Unlikely Edit (MUE) here.

Policy History

Date	Action	Reason

Medical Record Review

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

On occasion, Range Health may initiate a study or perform a review that requires medical record audits of Medicare Advantage members' charts. We will give physician offices adequate notice of any scheduled medical record reviews.

We ask that physician office staff assist with our Quality Improvement Program (QIP) process by providing copies of medical records (paper or electronic).

Policy History

Date	Action	Reason

Medical Records Standards

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Providers are required to maintain a medical record system that conforms to professional medical practices, facilitates audits and clam reviews, and ensures appropriate follow-up treatment. The minimum standards are as follows:

- Every page in the record contains the date of service, member's name and member ID number.
- The record includes the member's address, employer, home and work telephone numbers and marital status.
- The record is legible to a physician reviewer.
- Significant medical conditions are indicated on the problem list.
- The record includes treatment and action plans that are consistent with findings.
- The records include a health-maintenance plan.
- Medication, allergies, and adverse reactions are prominently noted.
- For adults, medical history including serious accidents, illnesses, and surgeries are recorded.
- For children, medical history including prenatal care, birth, childhood illnesses, and surgeries are recorded.
- The record includes notes about substance abuse, and use of tobacco and alcohol.
- The record contains subjective and objective information about complaints.
- The record includes lab work and other studies that have been ordered, as appropriate.
- Working diagnoses are consistent with findings.

- The record notes any follow-up care needed, including patient instructions on when follow-up is due.
- Unresolved problems from previous visits are addressed in subsequent visits.
- If a referral is made for consultation, a note from the consultant is included in the record.
- Consultation, lab, and X-ray reports included in the record are initialed by the primary care provider (PCP), or some other means is used to indicate that they have been reviewed.
- The record contains evidence that appropriate immunizations, screenings, and counseling have been provided in accordance with preventive health guidelines.
- Each encounter in the medical record should include a legible version of the provider's name and credentials. This may be fulfilled by a legible provider signature followed by credentials. Signature stamps are no longer accepted.
    - The medical record may be electronically signed. The signature in such a record must name the provider and indicate that the record was: [Electronically] Signed by, Authenticated by, Approved by, Completed by, Finalized by, or Validated by.
    - The following are not considered acceptable electronic signatures: Created by, Received by/for, Generated by/for, Administratively signed by, Dictated by not signed, Electronically signed to expedite delivery, Proxy signature (signed via approval letter or statement).
    - Documentation of the date the electronic signature was completed must be within 180 calendar days of the encounter. This includes amendments.
    - Handwritten signatures on paper medical records do not need a signature date.
- The record includes identification of all providers participating in the member's care, and information regarding furnished services.
- The record includes prescribed medications, including dosages and dates of initial or refill prescriptions.
- The record includes information and documentation in a prominent place if the individual has executed an Advance Directive.
- The record includes physical examinations, necessary treatment, and possible risk factors for the member relevant to the particular treatment.

All medical records should be kept for at least 10 years after the date of the last medical service for which claims have been submitted.

Policy History

Date	Action	Reason

Medicare Advantage Member Appeals Process

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Medicare Advantage plans must comply with specific requirements to notify our members in writing when we deny a payment or request for service.

Range Health is responsible for providing our members with coverage information. Please refer our members to Range Health Medicare Advantage Customer Service when they have questions about their coverage.

Medicare Advantage plan members have the right to appeal decisions about payment for services and failure to arrange or continue to arrange for services they believe are covered (including non-Medicare covered benefits) under Medicare Advantage. The Medicare Advantage member appeals process includes appeals for prescription drugs, Part C medical care or services and costs.

Pre-Service Appeals:

A provider may expedite a reconsideration request (appeal) on behalf of a member if they feel the standard reconsideration timeframe adversely affects the member's life, health or ability to regain maximum function. Upon providing notice to the member, a treating physician may request standard service reconsideration (appeal) on that member's behalf. Providers do not need to obtain an appointment of representation document from the member, nor are they required to execute a waiver of enrollee liability.

Examples of commonly appealed coverage decisions include:

- Services not yet received, but which the member feels Medicare Advantage is responsible for paying or for arranging.
- Discontinuation of services the member believes to be medically necessary.

Providers may submit a letter of support for member initiated standard appeals.

For complaints that do not involve coverage decisions, members should follow the Medicare Advantage grievance procedure. Medicare Advantage has both a standard determination and appeals procedure and an expedited determination and appeals procedure. Members can find complete information on appeals and grievance procedures in their Evidence of Coverage (EOC). When members have questions about which complaint process to use, refer them to Medicare Advantage Customer Service. Providers can request a copy of the plan's EOC by calling Medicare Advantage Customer Service.

Providers agree to cooperate fully with identification, investigation and resolution of any member complaint under the grievance and appeals procedures as set forth in the EOC. Providers also agree to cooperate fully and agree to accept as final and binding, decisions resulting from the reconsideration and appeals process. The appeals process does not apply to a doctor's determination of an appropriate medical treatment plan for their patient. If a patient and doctor discuss a service the doctor does not believe is medically indicated, please document the discussion in the patient's medical record.

Should any dispute arise later, documentation in the member's medical record will assist in an appropriate resolution. If a member requests a service that their doctor does not believe is medically indicated, contact the Medicare Advantage care coordination team. They will issue the appropriate documentation for denied services as required by the Centers for Medicare and Medicaid Services.

Policy History

Date	Action	Reason

Medicare Advantage Rights and Responsibilities

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Member Rights

As a Medicare Advantage provider, your patient has the right to:

- Be treated with dignity, respect, and fairness always.
- Receive these rights and services in a culturally competent manner regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed age, religion, or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care as defined in Civil Rights Act, Title Four, American Disability Act, Age Discrimination Act and Rehabilitation Act.
- Receive information in alternative formats, large print, Braille, languages other than English or other alternate formats.
- Receive free language interpreter services in any language.
- Patients eligible for Medicare because of a disability will be provided information about the plan's benefits that is accessible and appropriate for the patient.
- See plan providers, get covered services, and get prescriptions filled within a reasonable period.
- Be granted privacy of medical records and personal health information.
- Request a copy of your company's privacy practices.
- Receive confidential treatment of all communications and records pertaining to their care. They have the right to access their medical records. Range Health and service providers must provide timely access to their records and any information that pertains to them. Except as authorized by state law, Range Health and service providers must get written permission from the member or their authorized representative before

medical records can be made available to any person not directly concerned with their care or responsible for making payments for the cost of such care.

- Extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care.
- Receive Medicare Advantage general coverage and plan comparison information.
- Receive information about utilization control procedures such as obtaining information about their coverage and rules that must be followed when using coverage.
- Have access to statistical data on grievances and appeals.
- Have access to information about the financial condition of Range Health.
- Obtain information about network pharmacies, providers, prescription drugs, medical care, covered services, and costs.
- Receive information about their medications – what they are, how to take them and possible side effects.
- Obtain information about why something is not covered and what to do about it.
- Examine and receive an explanation of any bills for non-covered services, regardless of payment source.
- Know the names and qualifications of physicians and healthcare professionals involved in their medical treatment. Receive information about how medical treatment decisions are made by the contracting medical group or Medicare Advantage plan, including payment structure.
- Know treatment options and participate in decisions about healthcare.
- Receive information about any proposed treatment or procedure they may need to give an informed consent or refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment descriptions, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each and the name of the person who will perform the procedure or treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms they can understand.
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts responsibility and consequences of the decision).
- Be involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.
- Complete an advance directive, living will or other directive to the contracting medical providers.
- Receive reasonable continuity of care and know in advance the time and location of an appointment, as well as the medical provider providing care.
- Be advised if a provider proposes to engage in experimentation affecting their care or treatment and have the right to refuse to participate in such research projects.
- Be informed of continuing healthcare requirements following discharge from inpatient or outpatient facilities.

- Obtain information about Range Health plans, including information about financial conditions and how Range Health plans compare to other health plans.
- Have access to a summary of provider compensation agreements.
- Have access to a summary of Range Health's quality improvement plan.
- Expect these rights to be upheld by both Range Health and contracting providers.

Medicare Advantage Member Responsibilities

As a Medicare Advantage provider, your patient has the following responsibilities to:

- Provide doctors and other healthcare givers the information needed to care for them.
- Tell their providers that they are enrolled in our plan and provide any other health insurance coverage information.
- Treat all plan providers and personnel courteously and behave in a manner that supports the care given to other patients and the general functioning of the facility.
- Communicate openly with their provider and develop patient/provider relationships based on mutual trust and cooperation.
- Accept the financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a provider or while the patient is in a facility.
- Accept financial responsibility for any premiums associated with membership in their evidence of coverage.
- Be familiar with covered services and the rules that must be followed to get these covered services.
- Use plan providers when applicable (obtain referrals) and present their member identification card when accessing medical services.
- Ask questions of their provider regarding their medical treatment of Range Health Medicare Advantage regarding suggestions, concerns, or payment issues.
- Tell Range Health if they have moved.
- Call Customer Service for help if they have questions or concerns.

Policy History

Date	Action	Reason

Notice of Medicare Non-coverage (NOMNC) Reporting

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

The Centers for Medicare and Medicaid Services (CMS) requires all skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehab facilities (CORFs) provide a Notice of Medicare Non-Coverage (NOMNC) to each patient at least two days prior to discontinuation of services. This notice informs the patient when their services will end, Medicare appeal rights available, and how to request a fast-track appeal.

Notice of Medicare Non-Coverage

Instructions for the Notice of Medicare Non-Coverage

When a denial is rendered based on medical necessity, Range Health's Medical Management department works with the facility or agency and coordinates delivery of the NOMNC to the patient within the required timeframe. Although Medicare health plans are responsible for either making or delegating the decision to end services, SNFs, HHAs or CORFs are responsible for delivering the notices to patients or their authorized representative. Contracting providers not providing the notice of termination of services within the required timeframe may be financially liable due to a denial based on medical necessity.

Termination Notice Delivery

If a member does not receive valid notice, their coverage continues for at least two days after they receive, sign, and date the notification.

Methods of termination notice delivery in order of importance:

1. In person
2. By telephone
3. By certified mail

In Person Notification

We require our medical management and SNF, HHA and CORF providers to use the standardized CMS notice.

The standardized notice must contain:

- The end date of coverage of services (at least two days prior to service termination).
- The date a member's financial liability begins (two days after providing notice and termination of services).
- A description of the member's right to a fast-track appeal with the Quality Improvement Organization (QIO).
- How to contact the QIO.
- How to receive detailed information on why the member's coverage is ending.

To document receipt, the member must sign and date the notice received.

Telephone Notification

If personal delivery is not immediately available, we may notify a member's authorized representative by telephone.

For telephone notification, the following is required:

- For a valid notification, the provider representative is required to adequately convey the termination of services.
- Documentation, including the date and time of the phone conversation, must be noted in the member’s record. The date of the phone conversation is considered the date of receipt of notice.
- Confirmation of telephone contact is required by sending written notification by certified mail the same day.

Certified Mail

When phone contact is not possible, the provider should send the notice via certified mail with return receipt requested understanding that the following applies:

- The date of receipt is the date when someone at the address of record signs for the notification.
- If the post office returns the notification with no indication of a refusal date, member liability begins on the second working day after the provider’s mailing date. Providers should maintain a copy of the NOMNC in the patient's medical record and fax a copy to Range Health's Medical Management department.

Policy History

Date	Action	Reason

Outpatient Code Edits and Remittance Advice Codes

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

All Medicare Advantage outpatient facility claims run through the Outpatient Code Editor (OCE). Range Health has mapped very specific explanation codes for each of the OCE edits and will list exactly which edit occurred on your claim. These detailed explanations will show on your paper remittance advice, viewable on the web, but do not specifically translate to the electronic 835 file which contain only HIPAA compliant transactions.

An OCE edit can cause your claim to deny on the line level, deny on the claim level, or suspend in the claims processing system. Often, an edit on just one line item will cause a claim to hit a 'Return to Provider' (RTP) status. In this event, you will see a more specific remit message code on the line item hitting the edit, although all line items on the claim will show a $0.00 allowance.

For a complete listing of current OCE edits, you can visit the CMS website and view the quarterly updates.

Policy History

Date	Action	Reason

Participation Requirements

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete. or modify this policy in accordance with our provider contracts.

Policy

The Centers for Medicare and Medicaid Services (CMS) requires the following:

- Providers agree to cooperate with an independent quality review and improvement of the organization's activities pertaining to provision of services for Medicare members in Medicare Advantage.
- Providers comply with Medicare Advantage's medical policies, quality improvement projects (QIP), and quality management program. Medicare Advantage must develop these policies, programs, and standards in consultation with contracting providers.
- Providers agree to allow appropriate personnel of Medicare Advantage, Health and Human Services, Comptroller General, and other designees of these agencies to inspect, evaluate, and audit any pertinent books, documents and records relating to services provided to Medicare Advantage members.
- Medicare Advantage and its providers agree to provide all covered benefits in a manner consistent with professionally recognized standards of health care and services and must provide them in a culturally competent manner.
- Medicare Advantage must disclose to CMS the quality and performance indicators for the beneficiaries under the plan regarding disenrollment rates for members enrolled in Medicare Advantage for the previous two years.
- Medicare Advantage must disclose to CMS the quality and performance indicators regarding member satisfaction with the plan and their providers.
- Medicare Advantage must disclose to CMS the quality and performance indicators regarding health outcomes of members.
- **Summary of Benefits**

Please refer to the current year product specific summary of benefits and evidence of coverage for benefit details

Policy History

Date	Action	Reason

Place of Service

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

On-Campus Outpatient Department – a hospital-owned clinic that is within 250 yards of the main campus.

Off-Campus Outpatient Department – a hospital-owned clinic that is more than 250 yards away from the main campus.

Follow standard coding guidelines when choosing a place of service (POS) code. For qualifying provider-based clinics, utilize POS codes 19 (Off-Campus Outpatient Hospital) or 22 (On-Campus Outpatient Hospital) following the Centers for Medicare and Medicaid Services (CMS) guidelines.

Professional services performed in an on-campus outpatient department of a hospital are billed with POS 19 (off-campus outpatient hospital), or 23 (emergency room), depending on where the service was rendered.

Professional services performed in an off-campus outpatient department of a hospital are billed with POS 19 (off-campus outpatient hospital).

Professional services performed in an inpatient setting are billed as POS 21 (inpatient hospital).

The POS is noted on the CMS1500 form, or electronic equivalent, in Box 24B.

Range Health's clinical editing will deny claims billed with an incorrect POS code if not appropriate with the CPT/HCPCS codes that are billed.

A complete list of POS codes are listed below or can be found in the current year Current Procedural Terminology (CPT) book.

RANGE HEALTH

PLACE OF SERVICE CODES

Place of Service Code	Place of Service Description		Place of Service Code	Place of Service Description
01	Pharmacy		33	Custodial Care Facility
02	Telehealth Other Than Patient's Home		34	Hospice
03	School		35-40	Unassigned
04	Homeless Shelter		41	Ambulance – Land
05	Indian Health Service - Free-Standing Facility		42	Ambulance – Air or Water
06	Indian Health Service Provider-Based Facility		43-48	Unassigned
07	Tribal 638 Free-Standing Facility		49	Independent Clinic
08	Tribal 638 Provider-Based Facility		50	Federally Qualified Health Center
09	Prison/Correctional Facility		51	Inpatient Psychiatric Facility
10	Telehealth Provider Patient's Home		52	Psychiatric Facility Partial Hospitalization
11	Office		53	Community Mental Health Center
12	Home		54	Intermediate Care Facility/Individuals with Intellectual Disabilities
13	Assisted Living Facility		55	Residential Substance Abuse Treatment Facility
14	Group Home		56	Psychiatric Residential Treatment Center
15	Mobile Unit		57	Non-residential Substance Abuse Treatment Facility
16	Temporary Lodging		58	Non-residential Opioid Treatment Facility
17	Walk-in Retail Health Clinic		59	Unassigned
18	Place of Employment/Worksite		60	Mass Immunization Center
19	Off-Campus - Outpatient Hospital		61	Comprehensive Inpatient Rehabilitation Facility
20	Urgent Care Facility		62	Comprehensive Outpatient Rehabilitation Facility
21	Inpatient Hospital		63-64	Unassigned
22	On-Campus - Outpatient Hospital		65	End-Stage Renal Disease Treatment Facility

23	Emergency Room - Hospital		66	Programs of All-Inclusive Care for the Elderly (PACE) Center
24	Ambulatory Surgical Center		67-70	Unassigned
25	Birthing Center		71	Public Health Clinic
26	Military Treatment Facility		72	Rural Health Clinic
27-30	Unassigned		73-80	Unassigned
31	Skilled Nursing Facility		81	Independent Laboratory
32	Nursing Facility		82-98	Unassigned
			99	Other Place of Service

References:

Code of Federal Regulations: Title 42:413.65

American Medical Association, Current CPT, and associated publications

Centers for Medicare and Medicaid Services, CMS Manual System

Policy History

Date	Action	Reason

Primary Care Providers (PCPs)

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

A Primary Care Provider (PCP) is responsible for providing routine health care, including preventive health exams and treatment for illness and injury. A PCP is also responsible for coordinating the member's healthcare with other participating providers, including providing medical records to any other provider participating in a member's care. Physician assistants may be considered a primary care provider (PCP) when credentialed and contracted under the specialties of family practice, general practice, pediatrics, internal medicine, or obstetrics and gynecology. Nurse Practitioners may be considered a primary care provider (PCP) when credentialed and contracted under the specialties of family practice, general practice, pediatrics, internal medicine, or obstetrics and gynecology.

A PCP is a Physician, a qualified Physician Assistant, or a qualified Nurse Practitioner with one of the following specialty types:

- Family practice
- General practice
- Internal medicine
- Obstetrics & Gynecology
- Pediatrics
- Geriatrics
- Nurse Midwife (sponsor must have one of the above specialties)
- Licensed Nurse Practitioner (sponsor must have one of the above specialties)
- Nurse Clinical Specialist (sponsor must have one of the above specialties)

- Physician Assistant (PA) (sponsor must have one of the above specialties)
- Preventive Medicine

The PCP is responsible for maintaining procedures to inform members of follow-up care and provide training in self-care as necessary, and other measures taken to promote member's health.

All PCPs must follow the procedures for requesting prior authorization/referral, as necessary per each plan's specific requirements, whenever specialty care is needed. The PCP will provide necessary information to the authorized provider including related clinical summaries; history and physicals, results of diagnostic workups, treatment plans and progress notes, and other measures as needed to promote member's heath.

A PCP must provide periodic in person services in a clinical setting and therefore may not be a telehealth only provider.

Credentialing Process

Range Health defines credentialing as the process of verifying a provider's background (or credentials) to ensure quality of care for our members. Credentialing requirements vary and are dependent upon license type. The credentialing process can take between 90 – 120 days and is a separate process from contracting. Once a provider is credentialed and contracted, and are eligible provider types, they may now be designated as a member's PCP. Please reference Credentialing Recredential Standards for Practitioners.

Contracting Process

Contracting providers must meet Range Health licensing, accreditation and/or credentialing criteria, and have a signed contract with Range Health. Range Health offers contracts at the Tax Identification Number (TIN) level. To become a contracting provider under a new or changing TIN, Range Health requires the submission of paperwork, which may include a credentialing application, if appropriate.

If a provider needs to be added as contracting to an existing TIN with Range Health, he/she must submit paperwork for review.

Range Health implements new contracts with an effective date of 30 business days of receipt of a valid signed contract from the provider.

Adding a provider to an existing TIN takes between two and four weeks. Range Health will backdate the new provider's effective date, up to one year, if indicated on the Provider Information Sheet. Once we add the provider to your TIN, we will send you a letter indicating his/her effective date. Please hold your provider's claims until we add him/her to your TIN.

PCP Patient Panel Updates

A PCP has responsibility to notify Range Health when his/her patient panels are full, and he/she **can no longer accept new patients to** his/her **practices, or when** he/she can **accept new patients again.** Please use the Provider Update Form to notify us of these changes. Follow the instructions listed below:

1. Fill in the ***Practitioner Identification*** section and include the provider and clinic name, tax ID, organizational NPI and service location address.
2. Fill in the ***Practitioner Information Update*** section, specifically the box(s) ***Accepting New Patients***, ***Accepting Medicaid*** and ***Accepting Medicare***, if applicable.
3. Use the ***Notes and Instructions*** section to indicate the effective date of changes as well as who completed the form and updates**. Please note: Panel updates for commercial and Medicare Advantage contracts require 30 days written notice**.

PCP Changing Office Locations

We only designate a provider as a PCP at his/her primary location. If a PCP needs to change his/her primary practice location, please submit a Provider Update Form.

Policy History

Date	Action	Reason

Provider Communication

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health distributes all communications regarding contractual issues requiring a 60-day notification by email, fax or by United Postal Service (USPS).

Provider alerts will be combined and sent monthly, with the following exceptions:

- Alerts intended for targeted audiences, which are for specific provider specialties only.
- Alerts related to public emergencies or similar events
- Surveys
- Workshops

The alert will include a summary of the content and note the provider audience for each section on the alert. On the date of the communication, registered users on our provider website will receive the communication by email which will include links to each alert within that section. When an email address isn't available, the communication is sent the next business day by fax to the number supplied by the provider's office. When email addresses or fax numbers are not available or the communication failed to transmit by these methods, the communication is sent by USPS within 5-7 business days of the original communication date. The alert sent by fax or email will include instructions on how to find the information on the provider alert.

Policy History

Date	Action	Reason

Quality Improvement

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Our Quality Improvement Projects (QIP) continuously improves the quality of clinical care and services provided to our members from participating health care providers. By working with health care providers, a QIP integrates administrative services and health care delivery to improve the quality of care provided to members through data collection and analysis, member input, interventions to improve performance and other necessary means. QIP activities may include, but are not limited to, disease management, specialty-specific programs and other nationally recognized clinical surveys/projects. We achieve these goals by:

- Quality of Care and Service Oversight
    - Clinical or service opportunities through data collection and analysis (example: HEDIS Audit, CAHPS Survey)
    - Input from members on potential clinical or service opportunities
    - Oversight of delegated entities
    - Provider medical record review
- Quality Improvement Projects
    - Collaborate with physicians and representatives about quality, priorities and opportunities for improvement
    - Develop and implement interventions to improve performance
    - Evaluate the effectiveness of the interventions and modify the interventions for continual improvement

Examples of Quality Improvement Projects

The Center's for Medicaid and Medicare select topics for Medicare Advantage Plans. The 2012 to 2015 topic was Reducing Plan All-Cause Readmissions. The 2015 – 2018 topic is to

Promote Effective Management of Chronic Disease. The 2021-2023 topic is Management of Diabetes and Related Preventative Health Screenings, specifically focusing on the incidence of preventative health adherence for members diagnosed with diabetes.

Policy History

Date	Action	Reason

Quarterly Maximum Allowance Updates

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health defines maximum allowances subject to quarterly updates in provider contracts. Range Health will update the maximum allowances for impacted services by day 15 of the month at the beginning of a quarter when the additions, deletions or revisions are received by day 25 of the month from the pricing resource (i.e., Centers for Medicare and Medicaid Services (CMS)) prior to the start of the quarter. The quarterly update will be made effective on the first of the month to start the quarter (January, April, July or October). These updates do not apply to claims that have already been processed, and claims are not subject to adjustments.

Maximum allowances for vaccine codes are updated annually on August 1, or on the date received by CMS. Updates to vaccines do not apply to claims that have already been processed, and claims are not subject to adjustments.

Complex major mid-year updates by CMS may be implemented by Range Health on January 1 of the year following the update by CMS.

Refer to your provider contract for additional details on maximum allowance updates.

Maximum allowances that apply for out of network providers will be updated by day 15 of the month at the beginning of a quarter when the additions, deletions or revisions are received by day 25 of the month from CMS prior to the start of the quarter. The quarterly update will be made effective on the date designated by CMS, and claims will be adjusted if the update from CMS was retro-effective.

Policy History

Date	Action	Reason

Request for Member Education

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health Medicare Advantage customer advocates are required to make outbound verification calls to beneficiaries immediately after enrollment in a Medicare Advantage plan. This telephone call (or letter if the member cannot be reached by telephone on the first try) explains how the Medicare Advantage plan works and answers any questions they may have regarding their new coverage. These calls discuss using network providers, copayments, or coinsurances and using the Medicare Advantage identification card rather than the Medicare card.

To maintain and reinforce member education, we ask that you contact Range Health Provider Customer Service when your office has contact with a member you believe would benefit from additional education. We provide printed materials annually to all our members that include notification of coverage changes, evidence of coverage, provider directories and formularies (if applicable).

Policy History

Date	Action	Reason

Responsibilities of Contracted Specialists and Healthcare Professionals

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Contracted specialists and healthcare professionals are responsible for providing evaluation and treatment as requested by the Primary Care Physician (PCP) or member. If the member requires a procedure or service for which prior authorization is required, the contracted specialist or healthcare provider will submit a request with all pertinent medical documentation to the Range Health Medicare Advantage care coordination team allowing adequate time for medical review.

Contracted specialists and healthcare professionals are responsible for communicating medical updates to the member's PCP, including medical records, for incorporation into the member's primary care medical record.

The contracted specialist is responsible for maintaining procedures to inform members of follow-up care, and provide training in self-care, as necessary.

Policy History

Date	Action	Reason

Stars Quality Care Program

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Range Health Medicare Advance (MA) contracting providers are required to participate in the Stars Quality Care Program. Participation in these programs helps support complete and accurate submission to the Centers for Medicare and Medicaid Services (CMS) for Star plan performance. Rang Health's Stars Quality Care Program may include, but is not limited to the following activities: data analysis, reporting, provider education, on site evaluations, prospective patient evaluations programs, personal health assessment programs, clinic education, and medical record audits.

STARS QUALITY CARE PROGRAM PERFORMANCE METRICS

Average Star Rating Performance: Networks/clinics and participating clinic providers will be measured annually. Metrics will be calculated based all participating clinics' assigned membership assigned to the network/clinic, and performance calculation will be assigned to the applicable CMS Star ratings. The Star quality care rating specific to the Healthcare Effectiveness Data and Information Set (HEDIS) performance is applied to any payment as described in the examples below. These metrics measure the Network/Clinic's engagement in the CMS Star HEDIS programs and are vital to program success. No later than October 31 before the start of any plan year, Range Health will provide detailed guidelines of required HEDIS measures to calculate a clinic's performance level for the upcoming measure year.

Individual Star rating program performance metrics for participating clinics within a value-based arrangement are provided to the network/clinic quarterly.

Stars Quality Care Performance – HEDIS Quality Metrics	
Range	**Star Cut Points. Range Health Calculated HEDIS Star Rating**
4.75-5.0	5.0
4.25-4.74	4.5
3.75-4.24	4.0
3.25-3.74	3.5
0.00 – 3.24	<3.25
<3.25	0.5 Star Improvement from Prior Year

CMS STAR RATINGS: CMS uses a rating system referred to as Star rating to compare MA plans. The Star ratings emphasize patient care and satisfaction using national clinical and service quality measures, health outcomes, and patient feedback. The CMS Star rating measures can change annually. The network/clinic agrees to work diligently with its clinic providers to maintain or improve Star rating for their members. The network/clinic agrees to participate in the Quality Program HEDIS standard and nonstandard data submission by submitting electronic health record data through file feeds and/or medical records, at no charge to Range Health or its members, according to the National Committee for Quality Assurance (NCQA) HEDIS technical specifications and Range Health guidelines through a Secure File Transfer Protocol (SFTP) site. The network/clinic further agrees to work with Range Health staff, or a contracted third party, for the retrieval of qualifying member medical records, at no charge to Range Health or its members, required to satisfy the annual HEDIS audit requirements.

CMS developed the Medicare Star ratings to help consumers compare health plans and providers based on quality and performance, and reward top-performing health plans. The Medicare Plan Finder (MPF) tool allows consumers to search for health plans in their geographic area and compare cost estimates and coverage information. CMS rates the relative quality of service and care provided by MA organizations based upon a five-star rating scale that utilizes the contract level Healthcare Outcomes Survey measures combined with other measurement results. The Medicare Star ratings help Medicare beneficiaries compare MA plans, help educate consumers on quality and make quality data more transparent and comparable among plans. Multiple unique quality measures are included in the Medicare Part C and D Star ratings, including success in providing preventive services, managing chronic illness, access to care, HEDIS measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and responsiveness.

HEDIS Measures: HEDIS is a set of performance measures and specifications created by the National Committee for Quality Assurance (NCQA) to allow consumers to compare quality performance across health plans.

Policy History

Date	Action	Reason

Telehealth Virtual Care Services

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Telehealth virtual care services can be provided through synchronous or asynchronous telecommunication systems to deliver patient health services while following applicable state and federal laws, rules and regulations including Health Insurance Portability and Accountability Act (HIPAA). Telehealth may be used in lieu of an in-person care for CMS approved services listed on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .

Asynchronous: A term used to describe store and forward transmission of medical images or information, because the transmission typically occurs in one direction at a time.

Synchronous interaction: Real-time communication through interactive technology that enables a provider and a patient in two (2) separate locations to interact simultaneously through two-way video and audio or audio transmission.

Originating (host) Site: A qualified patient location where services are furnished via a synchronous telecommunication system.

Distant Site: The location where the provider is located at the time the professional services are furnished via a synchronous telecommunication system.

An active Interim Final Rule published by CMS applicable to telehealth services takes precedence over this policy.

Qualified patient locations for the originating site include those designated by CMS or as defined in an active interim rule.

Providers who may bill for distant site professional services (subject to State Law):

- Physician
- Nurse practitioner
- Physician assistant

- Nurse-midwife
- Clinical nurse specialist
- Clinical psychologist
- Licensed clinical professional counselor (LCPC)
- Clinical social worker
- Registered dietitian or nutrition professional
- Certified registered nurse anesthetist
- Physical therapists – Limited to online assessment and management services, virtual check-ins, and remote evaluation services
- Occupational therapists – Limited to online assessment and management services, virtual check-ins, and remote evaluation services
- Speech-language pathologists – Limited to online assessment and management services, virtual check-ins, and remote evaluation services

Limitations

Administrative services including, but not limited to:

- Scheduling
- Registration
- Updating billing information
- Sending reminders
- Requesting medication refills or referrals
- Ordering diagnostic studies
- Completing medical history intake with the patient is not covered as telehealth services

Standards for Telehealth Virtual Care Services

The following standards will be used by Range Health for services that are provided through telehealth:

- Member support for telehealth virtual care services:
    - Before the initial telehealth visit, the provider using the telehealth service is responsible to make sure that written information is given to the member in a way that the member can understand, informing them about telehealth, what to expect and what will occur.
    - If the member indicates at any time that they want to stop using telehealth, the service should end immediately, and an alternative appointment should be scheduled.

- Licensure:
    - Providers must maintain current state licensure and maintain standards of care within their scope of practice.
- Prior authorization:
    - The same prior authorization protocols and requirements apply whether services are delivered in person or through telehealth.
- Clinical documentation:
    - Member consent and other releases should be developed and maintained in the patient's medical record.
    - Providers must develop and maintain documentation as required by Medical Records Standards. The notes should be the same as those completed during an in-person visit, except for noting the mode of communication (i.e., Skype).
    - Providers must develop and document evaluation processes and member outcomes related to the telehealth program, visits, provider access and member satisfaction.
- Medical Necessity
    - The services must be medically necessary and follow evidenced-based standards of care.
- When using hosted telehealth services:
    - The originating and distant sites must ensure that policies and procedures addressing the provisions of telehealth to include all aspects of administrative, clinical, and technical components are in place prior to providing telehealth services.
    - The telehealth originating (host) and distant sites must ensure appropriate staff is available to meet the patient and provider needs before, during and after the telehealth encounter.
    - Only the originating site may bill for the originating site facility fee. The distant site physician or practitioner cannot bill or receive payment for facility fees associated with the professional service provided through an interactive telecommunications system.
    - Only the physician or practitioner at the distant site can submit claims for the professional service provided.
    - If using host and distant-site providers, following the telehealth session – if the hosting provider is not the member's primary care provider (PCP) – the distant-site provider is required to communicate a summary of results to the PCP using secure methods (e.g., email/fax, secure email, transmit to EMR), as well as to the member, unless the member has requested a limitation on such communication.
    - If an operator, who is not an employee of the agency involved, is needed to operate the teleconferencing equipment, or is present during the session, they must sign a confidentiality agreement. This statement should be filed with other documentation for the teleconference, such as a post-conference evaluation form.

- Claim submission:
    - Claims must be submitted under the provider's NPI who is providing the services.
    - Submission of telehealth services follows nationally accepted CPT/HCPCS coding standards.
    - Claims for professional services (distant site) must be billed with a place of service indicating telehealth (02 or 10) along with the appropriate telehealth modifiers.
    - Claims for originating (host) site must be billed with CPT Q3014-telehealth originating site facility fee, with place of service of 11-office.
    - Claims for telehealth services should follow current Medicare guidelines including, but not limited to, the use of appropriate procedure codes, modifiers, and diagnosis codes.

Modifier	Modifier Description	Billing Instructions
GT	Service provided through audio and video telecommunication system	Medicare plan members
GQ	Service provided through asynchronous telecommunications system. Service includes video or captured image.	Medicare plan members
95	Synchronous telemedicine service rendered via a real time interactive audio and video telecommunications system.	Medicare plan members

Policy History

Date	Action	Reason

Timely and Quality Care

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

As a Medicare Advantage member, your patient has the right to:

- A choice of qualified contracting Primary Care Physician (PCP), as applicable.
- Self-referral to a contracting woman's health specialist for women's health care issues.
- Self-referral to contracting provider for mammography screening and influenza vaccinations.
- A discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- Timely access to the member's PCP and referrals to specialists when medically necessary.
- Access to emergency services without prior authorization when the member, as a prudent layperson, acted reasonably, believing that an emergency medical condition existed. Payment will not be withheld in cases where the member sought emergency services.
- Actively participate in decisions about their own health and treatment options.

Policy History

Date	Action	Reason

Use of Modifiers

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right to add, delete, or modify this policy in accordance with our provider contracts.

Policy

Below are the most frequently questioned modifiers; however, this list is not all-inclusive. For further information, please refer to coding and the Centers for Medicare and Medicaid Services (CMS) sources or contact your Range Health Provider Relations representative.

Distinct Procedural Service Modifiers

CMS established HCPCS modifiers to define subsets of modifier 59. Providers are required to use the most appropriate modifier when billing. The new subset modifiers will be required in place of modifier 59 when appropriate.

Subset modifiers are designed to reduce improper use of modifier 59 and improve claims processing for providers. The modifiers are:

- XE – Separate Encounter; A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.
- XS - Separate Structure; A service that is distinct because it was performed on a separate organ/structure.
- XP - Separate Practitioner; A service that is distinct because it was performed by a different practitioner.
- XU - Unusual Non-Overlapping Service; The use of a service that is distinct because it does not overlap the usual components of the main service.

Ambulance Modifiers

Ambulance providers are required to submit claims showing an origin and destination modifier. We will deny claims without an origin and destination modifier and the origin zip code for corrected billing.

Valid origin and destination modifiers include the following:

Modifier	Meaning
D	Diagnostic or therapeutic site other than **P** or **H** when used as origin codes
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (airport or helicopter pad between modes of ambulance transport)
J	Free standing non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician`s office (including HMO non-hospital facility, clinic)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office in route to the hospital (includes HMO non-hospital facility, clinic) Note: Modifier X can only be used as a designation code in the second modifier position

Note: Use modifier QL when someone calls for an ambulance, but the member expires before the ambulance arrives at the scene. Payment for ambulance services with this modifier is acceptable, except for mileage or rural adjustment.

Chiropractic Service Modifiers

Submit manipulation codes using the AT modifier to indicate the services are active treatment.

DME Rental Item - Partial Month

KR modifier is used for a rental item billing for partial month. This modifier is used by suppliers who determine that services were only supplied for a partial month.

If Range Health discovers that a member’s equipment is supplied for a partial month, we reserve the right to prorate the service and allow the number of days the equipment was used by the member.

X-Ray Taken Using Film

Providers submitting charges for radiology services using film are required to submit the CPT with modifier FX, which will result in the applicable payment reduction of 20 percent of the Medicare Physician Fee Schedule (MPFS) on the technical component.

Habilitative Services

Providers need to include SZ modifier on HCPCS codes billed for habilitative services.

Multiple Surgery Modifiers

Ambulatory surgical centers with claims for multiple surgical procedures occurring on the same day must bill each surgical procedure on its own claim line. Append the modifier 51 to all secondary and subsequent surgical procedures.

Returning to Operating Room Modifiers

Use CPT Modifier 78 for surgical procedures that require a return to the operating room for a related procedure during the post-operative period. For this type of service, Range Health calculated allowance is 70 percent (70%) of the maximum allowance or the billed charge, whichever is less.

Sex-Specific Procedures and Diagnoses

Providers are required to submit KX modifier on professional claims (CMS1500) or Condition Code 45 on institutional claims (UB04) when billing for sex-specific procedures and diagnoses for an individual that identifies with the other gender to follow the Federal nondiscrimination requirements.

Therapy Modifiers

For proper claim processing, include one of the therapy modifiers listed below for physical therapy, occupational therapy and/or speech therapy claims:

1. **GN** - Services delivered under an outpatient speech-language pathology care plan.
2. **GO** - Services delivered under an outpatient occupational therapy care plan.
3. **GP** - Services delivered under an outpatient physical therapy care plan.

Therapists should use the appropriate physical therapy modifier for wound therapy claims.

Vision Care Modifiers

Use the SC (medically necessary service or supply) modifier in the primary position for post cataract appropriate hardware claims. Append this modifier to the hardware codes only.

Submit claims for optical services without the SC modifier when a member's vision benefit applies.

Policy History

Date	Action	Reason

Using Claims for Primary Care Provider (PCP) Attribution

Provider Administrative Policy

Policy Date
July 2025

Status/Date
New July 2025

Disclaimer

Our provider administrative policies contain information regarding claims submission, reimbursement, and other information to achieve an efficient relationship with our providers. These policies are not an authorization or explanation of benefits. Range Health retains the right, delete, or modify this policy in accordance with our provider contracts.

Policy

For contracts that require members to choose a Primary Care Provider (PCP), Range Health uses claims data to assign a PCP to members who have not chosen a PCP or whose selected PCP may not be their current/correct provider. When members have a current PCP assigned to them, providers have the most up-to-date information on members and can better provide high-quality, low-cost care, facilitate coordinated care and reduce healthcare. This policy applies to Medicare Advantage (MA) plans.

Range Health uses patient selection, auto-assignment and the following methodology to PCPs assign members:

1. The look back period for claims is eighteen months. The servicing provider who provided the most recent wellness visit or preventive exam to a member will be assigned as the member's in-network PCP.
2. If no wellness or preventive exam visit has been coded in the last eighteen months, we will review claims from a PCP-type provider. If the PCP has billed more than two visits with no urgent care modifiers, the provider will be assigned as the member's PCP. The most recent claims will supersede older claims in the eighteen month look back period.
3. If there are no claims, a member will be assigned to a PCP based on the member's zip code and PCPs who are accepting new patients.

Claims excluded from the data include urgent care services, hospital-based providers and denied claims.

If you are not currently a PCP and would like to be, complete and submit the Provider Request for Update form. To update your PCP status on the form, scroll to ***Patient Parameters*** under ***Practitioner Information Update*** and select ***Yes*** for ***Primary Care Physician***.

Policy History

Date	Action	Reason