Welcome to Community Health Choice

Welcome to the Community Health Choice, Inc. (Community) Health Insurance Marketplace (Marketplace) Provider Manual. This manual will allow you to quickly reference the information your office needs to effectively and efficiently interface with us.


Local: 713.295.6704
Toll-free: 1.855.315.5386
Fax: 713.295.7039
E-mail: ProviderRelations@CommunityCares.com
Web site: www.CommunityCares.com
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Marketplace Service Area Coverage Map by Counties

Brazoria, Chambers, Fort Bend, Galveston, Harris, Jefferson, Montgomery, Orange, and Waller counties.
Introduction

About Community Health Choice
Community Health Choice, Inc. (Community) is a local non-profit health plan, licensed Health Maintenance Organization (HMO) providing services to Texas residents. At Community, we genuinely CARE for and SERVE our Community. We are a TRUSTED partner who RESPECTS our Members and their families, opens doors to high-quality healthcare, and makes the process EASY. Even more simply, we say Community Cares.

This manual is intended to support Providers and contracted entities. Community is sensitive to the demands on the Provider’s time and resources and is dedicated to offering the support needed by streamlining our administrative procedures.

Pledge to our Providers
To the Providers, Community pledges:

• Easy access to Community Web site, by phone or by personal visit from an assigned Provider Engagement Representative
• Fair and timely payment of clean claims
• Provider education and office staff training programs
• Active Care Management programs for chronic diseases such as asthma, diabetes or high-risk pregnancy (specifically diabetes, hypertension, previous preterm birth or multiples)
• Complex Case Management
• Communication on a regular basis that alerts Providers to upcoming events and initiatives sponsored by Community
• Quick Reference Guide

Mission Statement
At Community, our mission is to improve the health and well-being of under-served residents of Southeast Texas by opening doors to coordinated, high-quality, affordable healthcare and health related social services. Our mission is achieved through:

Community: Collaborating with community-based Providers and organizations to improve access, quality, coordination, and cost effectiveness of services

Health: Developing programs to establish medical homes, manage health conditions, and promote wellness and preventive care

Choice: Encouraging personal accountability and educated choices for individual and family health and well-being

Using the Provider Manual
The Provider Manual is designed as an informational and procedural guide for Community participating Providers and their staff, for Community’s contracted facilities, and for Community’s ancillary Providers. The manual contains instructions, a Quick Reference Guide, and Community policies and procedures that will assist Providers and their staff’s interaction with Community. When followed, this manual will decrease the paperwork and time your staff spends:

• Researching details of the benefit plans
• Obtaining prior authorizations for certain services
• Re-billing corrected claims
• Appealing adverse determinations

Material in this Manual is subject to change. The most recent information is also available on our Web site at www.CommunityCares.com. Updates and new services may be added periodically to the Manual. Community will post the revised information on our Web site from which you can print the revisions, if desired. Likewise, when Community develops
new policies/procedures or clinical practice guidelines, Community will post the most current versions on our Web site and alert Providers of their availability. Community will distribute a copy of the new policy, procedure or guideline, upon request.

You can request copies of the Provider Manual, by calling 713.295.6704 or from your Provider Engagement Representative.

The Provider Manual is designed solely as a guide. If differences, errors or omissions occur between this manual and either the Provider’s contract or the governing regulations, the contract and Texas Department of Insurance (TDI) regulations shall govern.

Code of Ethics
Community is committed to providing access to a quality network and healthcare delivery systems that provide healthcare in a manner that preserves the dignity, privacy, and autonomy of the Members.

To further this goal, Community Network Providers shall:

- Treat all Members with respect and courtesy
- Respond promptly to Members’ questions
- Ensure that Members have reasonable access to the services to which they are entitled under their health plan
- Assist Members (or their legal guardians, when appropriate) with making informed decisions about their medical care, including providing them with information about withholding resuscitative services, foregoing or withdrawing life-sustaining treatment or participating in studies or clinical trials. Providers, as required by law, shall obtain informed consent
- In making clinical decisions concerning a Member’s medical care, a Community Network Provider shall not allow himself/herself to be influenced by how the Provider or Provider network is financially compensated or by whether a particular treatment or course of care would be covered by the Member’s plan
- Avoid conflicts of interest. Network Providers making clinical decisions concerning a Member’s medical care should not be influenced by any financial interest they may have in any entity to which the Member has been or may be referred
- Maintain the confidentiality, as required by law, of information concerning Members’ medical care and health status
- Cooperate with QI activities
  - Allow Community to use their performance data
  - Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage

Health Insurance Portability and Accountability Act (HIPAA) of 1996

Electronic Code Sets and Standard Transactions
Federal regulations require covered entities (HMOs, physicians, hospitals, labs, pharmacies and other healthcare Providers) to comply with HIPAA-approved transactions and code sets for dates of service on or after October 16, 2003.

Privacy and Security Statement
As covered entities under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and its associated regulations, Community and all Providers and clearinghouses must adhere to “Protected Health Information,” and “Individually Identifiable Health Information” requirements as those terms are defined in the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (“HIPAA”), HIPAA regulations (codified at 45 C.F.R. Parts 160 and 164) or in regulations on Standards for Privacy of Individually Identifiable Health Information, including the HITECH Act.

One of the requirements of the HIPAA Privacy Rule is for covered entities to issue a Privacy Notice. The HIPAA Privacy Notice is on our Web site at www.CommunityCares.com.
Clearinghouse Billing

Community's Payer ID is 60495. Community receives electronic transactions for its Marketplace programs from the following clearinghouses:

- Emdeon 1.800.735.8254
- SSI 1.800.820.4774
- Availity 1.800.282.4548
- TKSoftware 1.402.593.6542
- RelayHealth 1.563.585.4411
- Trizetto Provider Solutions 1.800.969.3666
- Practice Insight 1.713.333.6000
- Community Web Portal www.CommunityCares.com

For further assistance, contact Provider Services, Monday through Friday, 8:00 a.m. – 5:00 p.m.

Local: 713.295.6704
Toll-free: 1.855.315.5386
E-mail: ProviderRelations@CommunityCares.com

- Claims Inquiries – For claims submitted more than 30 days from the time of call (Limited to three claims per call. Unlimited inquiries available via Web site.)
- Questions/Concerns
- Provider Changes
- Contract Terms
- Check Tracer

Note: It is important to remember that each Marketplace Member must be billed as “SELF”. Do not reference any family members. Complete only the highlighted portions as demonstrated below:

Corrected Claims

If your claim is denied because it did not contain critical claims elements that are required for adjudication of clean claims, or you did not submit as indicated above, you may submit your corrected electronic or paper claim with the resubmission code 7 in box 22 of the CMS-1500 claim form or in Loop 2300 electronically. You must indicate the original claim number in the Original Reference number field along with the resubmission code.
Failure to submit without the resubmission code 7 will result in your claim being denied for untimely filing or as a duplicate claim submission.

Note: Resubmitted or Corrected claims are not considered appeals. Do not send corrected claims to the Appeals Department. All corrected claims should respond to the error messages as delineated on the EOP. Claims adjudication status is available by mail or 24 hours a day on the Community Web site at www.CommunityCares.com 30 days after the submission of a clean claim.

Refunds
Make your check payable to:

Community Health Choice, Inc.
P.O. Box 4626
Houston, TX 77210-4626

Directory of Services

Provider Communications Hotline
Monday through Friday, 8:00 a.m. – 5:00 p.m.

- Claims Inquiries – For claims submitted more than 30 days from the time of call (Limited to three claims per call. Unlimited inquiries available via Web site.)
- Questions/Concerns
- Provider Changes
- Contract Terms
- Check Tracer

Local: 713.295.6704
Toll-free: 1.855.315.5386
E-mail: ProviderRelations@CommunityCares.com

Member Services

Monday through Friday, 8:00 a.m. – 5:00 p.m.

- Benefit Coverage and Eligibility Verification
- Physician Information
- Service Questions
- Specialist Referral Assistance
- Interpreter Services

Local: 713.295.6704
Toll-free: 1.855.315.5386
Fax: 713.295.2293
E-mail: MemberServices@CommunityCares.com

Medical Affairs

The Medical Affairs department consists of the following areas:

- Care Management
- Complex Case Management
- Notification of Emergency Services
- Prior Authorizations

Local: 713.295.6704
Toll-free: 1.855.315.5386
Pre-Authorizations Fax: 713.295.7019
Admission Notifications Fax: 713.295.2284
E-mail: MedicalAffairs@CommunityCares.com
Care Management Program
If a Provider has Community Members who are being managed for asthma, diabetes, heart failure or high-risk pregnancy (specifically diabetes, hypertension, previous preterm birth or multiples), they should refer them to Community’s Care Management Program. Community has nurses to assist Provider offices in the management of difficult-to-manage patients with either a chronic disease or a potentially catastrophic, high-risk pregnancy.

Local: 713.295.2303
Toll-free: 1.855.315.5386
TDD: 7-1-1
Fax: 713.295.7028

Complex Case Management Program
Community Health Choice offers Complex Case Management services to members with multiple or complex conditions.

The goals of the complex case management program is to help members regain optimum health or improved functional capacity in the right setting, utilizing the right providers, in the right time frame and in the most cost-effective manner.

Some of the conditions that may qualify for complex case management services are spinal cord injuries, transplants, cancer, multiple trauma, AIDS, premature infants on home ventilator, traumatic brain injuries, multiple chronic illnesses that result in high utilization of services such as frequent emergency room visits and avoidable hospitalization.

The complex case manager will assist the member in navigating health care services. Typical services provided by the complex case manager include but are not limited to care coordination, arrangement of medical and specialty appointments, and referrals to community resources.

To make a referral to the complex case management program, please call member services at 713-295-6704 or Toll-Free 1-855-315-5386.

Nurse Help Line
Community provides our Members with a nurse help line 24 hours a day, seven days a week, toll-free at 1.888.332.2730.

Pharmacy
Navitus Health Solutions
Toll-free: 1.866.333.2757
www.navitus.com

Member Rights and Responsibilities
Effective health care delivery requires a partnership between patients and their healthcare Providers. In order to facilitate an effective relationship between Providers and our Members, it is important for Community Members to understand their rights and responsibilities. Hence, Community has adopted the following Member’s Rights and Responsibilities statement:

As a Community Member, you have certain rights and responsibilities. Community is committed to ensuring that Members’ rights are protected.

Members have the right to:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.

4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

5. A right to voice complaints or appeals about the organization or the care it provides.

6. A right to make recommendations regarding the organization’s member rights and responsibilities policy.

Members have the responsibility to:

- Learn and understand each right they have and ask for help when they need it
- Follow all health care plan rules and policies
- Treat all doctors, health care Providers with respect and courtesy
- Inform Providers if they do not understand any type of care they are receiving or what is expected from them as part of a treatment plan
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Inform Member Services of any changes to name, address or family Members covered under a plan

Community is committed to providing high-quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are overseen by the Member’s signed benefit contract and not by this Member Rights and Responsibilities statement.

Provider Participation Criteria

Historically, through our rigorous Provider credentialing criteria and processes, Community has been willing to credential any Provider who met basic credentialing criteria, (e.g., participation as a Medicaid Provider and an attested TPI number). Community is now implementing a new process and expanded participation criteria, which will impact all future requests for physicians requesting participation in one of Community’s Provider networks. In addition, these same criteria and processes will be applicable to those Providers already contracted with and participating in one of Community’s Provider networks.

When a non-participating Provider makes an initial inquiry about joining Community’s Provider network, he or she will be asked to complete a profile form that outlines basic demographic information about the Provider’s practice (e.g., legal structure, specialty type, locations, etc.) and to attest to compliance with Community’s defined Provider Network Participation Criteria. Upon receipt of this documentation, the Network Management team will complete a Network Need Assessment. The Network Need for a Provider may be based on:

- Access and availability – a gap in the Provider network, a need to improve access and availability of a specific Provider type, or existing Provider network at capacity;
- Regulatory – gaps in language and/or cultural diversity of Provider network or as directed by an appropriate state or federal legislative or regulatory body;
- Accreditation – compliance with NCQA, URAC, and/or any other Community accrediting body;
- Continuity of care – a need to transition participation status from one Provider structure to another with existing membership (e.g., an individual Provider leaves a group practice and starts his/her own private practice);
- Strategy – creation of a distinct and documented Provider network or competitive advantage;
- Innovation – creation of a unique care delivery model and/or compensation methodology; or
- Other – approved in advance by the Vice President of Network Management.
• If Community determines that a Provider Network Need exists, a Network Management staff member will meet face-to-face with the interested Provider for the purpose of:

- obtaining missing information on the Provider Profile form;
- verifying that the Provider routinely offers a minimum of 35 appointment hours per week and is in compliance with any accreditation standards applicable to the type of Provider;
- documenting further information on any specific element of the Network Participation Criteria in which the Provider indicated non-compliance;
- sharing Community’s Mission and overall Provider Engagement Platform, including Community’s Provider Network Strategy, operational expectations regarding the Provider’s participation, and overall commitment to quality; and
- gathering additional intelligence regarding the Provider’s practice (e.g., list of preferred hospitals, participation with other Managed-Medicaid MCOs, experience managing or improving quality performance, future plans for growth or expansion, etc.).

Following the face-to-face meeting with a potential Provider in an area of identified Network Need, assuming adherence to Community’s new Network Participation Criteria, Network Management will submit an invitation to the Provider to join Community’s Provider network, including a request for completion of required credentialing information and signature on Community’s Provider Participation Agreement, with standard language and standard compensation levels as approved by the Contracting and Provider Reimbursement Committee.

For any Providers who maintain variances from the approved Network Participation Criteria, the Network Management staff member will forward all information to the Vice President of Network Management and the Senior Vice President of Medical Affairs, who in turn will agree on a final decision as to whether or not to extend the Provider an invitation to participate in Community’s Provider network; such invitation perhaps contingent upon the Provider’s adherence with any of the variances identified within a given timeline.

It is the expectation of Community Health that ALL Participating Physician will comply with the following Physician Provider Network Participation Criteria – unless otherwise approved on an exception based by leadership in Medical Affairs & Network Management.

<table>
<thead>
<tr>
<th>Criteria Type</th>
<th>Criteria</th>
<th>STAR</th>
<th>CHIP</th>
<th>HIM</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory</td>
<td>Participation in THSteps Program</td>
<td>X</td>
<td></td>
<td></td>
<td>Applies to PCP Providers only</td>
</tr>
<tr>
<td>Regulatory</td>
<td>Attested NPI Number</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulatory</td>
<td>Valid Medicare Number</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Preferred, but not Required. Does not apply to Pediatric or OB/GYN Providers.</td>
</tr>
<tr>
<td>Regulatory</td>
<td>Not currently on any government exclusion list</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Internet access at office/patient care setting</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Fax availability at office/patient care setting</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Hospital Privileges at a Participating Network Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Advanced approval of acceptable coverage such as by a hospitalist or designation agreement may substitute</td>
</tr>
<tr>
<td>Admin</td>
<td>Electronic Claims Submission</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Electronic Funds Transfer</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Admin</td>
<td>Electronic Remittance Advice</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>Adherence to HIPAA Standard Transactions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Admin Participation in CAQH Program | X | X | X

Quality Board Certification | X | X | X

Existing Providers who are not BC will be grandfathered. Existing Providers who are Board eligible but have not yet taken their Boards will be expected to have done so by his/her next re-credentialing date.

Quality Signed Commitment to Quality Statement | X | X | X

 Applies to PCPs and OB/GYNs only.

Quality Use of Electronic Medical Record | X | X | X

Not required, but if so capture vendor

Quality Use of Patient Satisfaction Measurement Tool | X | X | X

Not required, but if so capture sample of tool

Provider Credentialing

To ensure a quality network of providers and comply fully with regulatory requirements and internal standards, Community maintains well-defined policies and procedures related to initial credentialing, recredentialing, and ongoing monitoring of its Providers. The initial and recredentialing process begin with individual providers completing the Texas Standardized Application using the CAQH Proview repository. Community’s Credentialing Department will download a copy of the completed application, with attestation pages signed within 180 days, upon notification from the Contracting Department that a contract has been secured. All providers applying to the network must be reviewed and approved by Community’s Credentialing Committee prior to providing care to Community’s Members and be listed in the provider directory or other Member publications. Institutional (facility) providers are required to complete Community’s Ancillary or Hospital Credentialing Application, as applicable, which may be obtained directly from Community. The credentialing process typically takes 60 to 90 days from receipt of a completed application packet.

CAQH ProView

The Council for Affordable Quality Healthcare (CAQH) is a non-profit, mutual benefit corporation that has created a single system known as the CAQH ProView that meets the needs of nearly every health plan, hospital, and other healthcare organization. The CAQH ProView enables physicians and other healthcare professionals to enter information, free of charge, into a secure central database and then authorize healthcare organizations to access that information. The UPD eliminates redundant credentialing paperwork and reduces administrative burden. Community utilizes CAQH ProView for initial credentialing and recredentialing.

CAQH-Approved Provider Types

CAQH only accepts Provider data for the following approved list of Provider types:

- **Standard**: Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)

- **Allied**: Acupuncturist (ACU), Audiologist (AUD), Alcohol/Drug Counselor (ADC), Biofeedback Technician (BT), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Professional Counselor (PC), Licensed Practical Nurse (LPN), Massage Therapist (MT), Marriage/Family Therapist (MFT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Optometrist (OD), Optician (OPT), Dietician (DT), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP), Pharmacist (PHA), Physician Assistant (PA), Physical Therapist (PT).
Note: It may be necessary for Community Health Choice to contact you to supplement, clarify or confirm certain information submitted on your CAQH application.

CAQH Frequently Asked Questions: https://upd.caqh.org/oas/FAQ.aspx

Provider Portal

Community’s online Provider Portal offers secure, 24 hours a day, 7 days a week access to online tools and services. Providers can view Member eligibility and benefits, claim status, and the status of pre-authorizations. Additionally, the Provider Portal includes:

- Provider News
- Quick Links to Resources/Documents
- Provider Manual and Quick Reference Guides
- Credentialing information
- Commonly Requested Forms
- Policies and Guidelines
- Eligibility and Benefits Status
- Remittance Updates
- Referrals

Accessing Provider Portal

2. Enter your user ID and password.
3. Click “Login.”

If you do not have an account and you are currently contracted with Community:

1) Click “Register Today.”
2) Fill out the entire form to apply for a new account. Incomplete forms will cause delays.

If you have questions or issues during the registration process, please contact Provider Communications at 713.295.6704 or toll-free at 1.855.315.5386.

Member Eligibility

Verifying Eligibility

All Community Members are issued and mailed a Member ID Card. When verifying Member eligibility, ask for your patient’s Member ID Card. Make a copy of both sides of the card for the Member’s file. Before providing services, verify that you have received an authorization number for inpatient or required outpatient services. Failure to obtain authorization may result in a denial by Community.

You can check eligibility, benefits, and PCP selection online. To verify Member eligibility, use one of the following sources 24 hours a day, seven days a week:

- Community Online at www.CommunityCares.com. You will need to fill out the Community Secure Access Application to become an authorized user. Call Provider Relations to get more information.
- Community Provider Eligibility Services at 713.295.6704 or toll-free at 1.855.315.5386.
Be sure to have the following Member information when you call or go to Community Online:

- Name
- ID Number
- Date of Birth

**Member ID Cards**

The card issue date is the date the card was printed. The effective date is the date the benefits under the Member’s health plan were available to the Member. Please request the most current copy of a Member’s ID card at each visit.

**Sample Member ID Card**

![Marketplace ID Card](image-url)

You may be asked to present this card when you receive care. This card does not guarantee coverage. You must comply with all terms and conditions of the plan. Willful misuse of this card is considered fraud. In case of an emergency, call 9-1-1 or go to the nearest Emergency Room. Please call your Primary Care Provider as soon as possible for further assistance and directions on follow-up care within 48 hours.

**Inpatient and Outpatient Procedures:**
- Certain services require pre-authorization. Failure to do so may affect benefits.
- Please refer to your plan documents for your pre-certification requirements.

Provider Services: 713.295.6704 or toll-free at 1.855.315.5386

Eligibility, benefits, and claims: Monday - Friday, 8:00 a.m. - 5:00 p.m.

Authorization: Monday - Friday, 6:00 a.m. - 5:00 p.m.

Weekends and Holidays, 9:00 a.m. - 12:00 p.m.

Send Claims to: Community Health Choice, Inc. P.O. Box 301424 Houston, Texas 77230

Electronic claims: Payer ID 60495

Behavioral Health: 1.855.539.5881

Pharmacy: 1.866.333.2757

24-Hour Nurse Help Line: 1.888.332.2730
Network Providers

Selecting a Primary Care Physician or Provider (PCP)
In 2017, Community requires that Members select a Primary Care Provider (PCP) for themselves and for each covered dependent. Members who elect to participate with Kelsey-Seybold will be limited to the Kelsey-Seybold network of Providers. The following physician and provider types may serve as PCPs:

1. Physicians, and/or mid-level practitioners such as Physician Assistants (PAs) or Advance Practice Nurses (APNs) practicing in the specialties of:
   a. General Practice
   b. Family Practice
   c. Internal Medicine
   d. Pediatrics
2. Federally Qualified Health Plans
3. Rural Health Clinics
4. Specialty Physicians (for Members with a chronic, disabling or life-threatening illness)

If a Member has a chronic, disabling or life-threatening illness, he/she may request that Community’s Medical Director approve as a PCP, the Specialty Physician currently managing the chronic, disabling or life-threatening illness. The request must be made with the approval of the Specialty Physician requested.

Role of the Primary Care Provider
Providers serving in the role of PCP are responsible for:

1. Ensuring newly-assigned Members schedule appointments within the first ninety (90) days of enrollment to establish the Member as part of the PCP’s practice
2. Providing primary healthcare services, i.e., preventive care and/or care related to common or routine illness
3. Referring Members to other Participating Providers for needs other than primary healthcare services (referrals to Specialty Providers must be made within 24 hours for urgent care and within two weeks for routine care)
4. Complying with Community’s Commitment to Quality for Primary Care, as well as other Quality Improvement Programs, which may include periodic chart reviews
5. Maintaining an open panel for Membership

Provider Responsibilities
- Contact Community to verify Member eligibility prior to providing covered services
- Maintain confidentiality of Personal Health Information (PHI) for Community Members
- Maintain staff Membership and admission privileges in good standing with at least one hospital contracted with Community, unless otherwise approved
- Be aware of culturally-sensitive issues with Members
- Agree not to refer or direct patients to hospital emergency rooms for non-emergent medical services at any time
- Maintain both general liability and professional liability insurance of a type and in the amounts acceptable
- Meet all of the Community credentialing and re-credentialing requirements
- Submit and maintain claims using the assigned Community Provider and referral authorization number
- Maintain all medical records relating to Community Members for a period of at least 10 years from the initial date of service
- Comply with federal regulations that protect against discrimination and the federal Americans with Disabilities Act
• Maintain any and all licenses in the State of Texas as required by the laws governing his/her profession or business
• Notify Community of any policy or procedure that creates a barrier to care
• Cooperate with Community for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers’ compensation, third-party liens, and other third-party liability.
• Contracted Physicians agree to file claims and encounter information with Community even if the Physician believes or knows there is a third-party liability.
• Only bill subscribers for copayments, cost share (coinsurance), and deductibles, where applicable.
• Physicians will not waive or accept lower copayments or cost share or otherwise provide financial incentives to subscribers, including lower rates in lieu of the subscriber’s insurance coverage.
• Agrees to participate with Community’s Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) under the terms and conditions set forth in the EFT Agreement and as described on the ERA Enrollment Form
• Cooperating with Community’s Care Management Program, by providing clinical information when necessary and participating in care plan development for Community Members with chronic diseases
• Reporting pregnancies to Community’s Medical Affairs Department within 24 hours of occurrence or by the next business day
• Monitoring the progress of a Member’s care and coordinating utilization of services to facilitate the return to the Primary Care Provider as soon as medically appropriate
• Assisting Members as needed to ensure receipt of quality, cost-effective healthcare
• Helping Members understand Member rights, responsibilities, and obligations as it relates to the receipt of healthcare services
• Educating Members and their families regarding their needed healthcare services
• Cooperating with Community’s Utilization Management Program as articulated in Community’s Utilization Management (UM) Plan
• Adherence to any/all requirements related to Community’s Health Plan accreditation
• Assist in educating and instructing Community Members about the proper utilization of Provider office visits in lieu of the emergency room
• Cooperate with QI activities
  - Allow Community to use their performance data
  - Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage

**Referral to Specialists and Health-Related Services**

PCPs should provide a medical home to Community Members. The PCP has the primary responsibility for arranging and coordinating appropriate referrals to other Providers/specialists as well as managing and coordinating the administrative functions related to the delivery of health services in conjunction with Community and case managers as indicated.

The PCP or designee may make medically-necessary referrals to specialists for family planning, mental health and emergency services without authorization from Community. A list of these Providers is available online.

Authorizations for referrals to in-network specialists are not required.
Specialist as “Provider”

Specialist physicians may be designated as the “Provider” or “Medical Home” for a Community Member with complex, multi-system disease or with chronic conditions and who requires a level of service coordination or technology that is beyond the scope and role of the usual Primary Care Provider. This designation of a Provider requires prior authorization. Authorization may be given for up to one year.

Specialists who become Providers must meet and adhere to the following criteria as they manage the care to Members with complex conditions:

- Have demonstrated expertise in treating a particular disease and/or condition
- Agree to abide by Community’s policies and procedures
- Agree to provide primary care according to primary care standards
- Agree to provide 24-hour, seven-day-a-week, on-call coverage through a system staffed by other similarly-qualified physicians

The Case Manager, Primary Care Provider or Specialist may request Medical Affairs’ authorization of the Specialist as the designated “Provider” for a Member with complex medical issues by providing the following information:

- Patient’s full name
- Age
- Sex
- Primary diagnosis
- Secondary diagnosis
- Highlights of medical history
- Identification of all physicians involved in the care of the patient and scope
- Rationale for request

The specialist must be approved by the Medical Director. The specialist must sign a statement stating that he/she is willing to accept responsibility to serve as the Member’s “Provider.” The Member must sign a statement indicating consent for the specialist to serve as “Provider.” Community’s Medical Director will approve or deny the request for special consideration as previously outlined in this section and provide written notification of the decision to the enrollee, no later than 30 days after receiving the request. If the request is denied, Community will provide written notification to the Member including the reason(s) for the denial along with information on how to appeal the decision through the complaint and appeals process.

Community’s Medical Director will consult and communicate directly with both the original Primary Care Provider and the specialist being designated as the “Provider” to explore and suggest other alternatives and communicate his/her decision on the request. When needed, the specialist designated as the “Provider” will continue to collaborate closely with the Case Manager for intensive case management or coordination of care for the Members.

The effective date of the “Provider” designation will be the day it is approved by Community’s Medical Director. The effective date may not be applied retrospectively. The specialist will remain as the “Provider” designee as long as the patient’s needs warrant this level of expertise and meet Community’s policy. Annual authorization is required.

Specialty Care Provider Responsibilities

Specialists should discuss all medical needs with the PCP. Although Community allows open access to Specialty Care Physicians without a referral from a PCP or authorization from Community, if a Member and his/her PCP determine that there is a need to see a Specialty Care Physician, the PCP can recommend one specific to the Member’s medical needs.

Community requires prior authorization for certain services. Go to www.CommunityCares.com for a list of services that require prior authorization.
Specialists are responsible for furnishing medically-necessary services to Community Members who have been referred by their PCP for specified consultation, diagnosis and/or treatment. The specialist must communicate with the PCP regarding services rendered, results, reports, and recommendations. To ensure continuity of care, all medical record documentation of services rendered to the patient should be forwarded to the PCP. To authorize services, please call 713.295.6704 or fax 713.295.2283 (in-patient) or 713.295.2284 (out-patient) or submit an authorization on our Web site at www.CommunityCares.com.

Plan Termination
A PCP who elects to terminate Community participation must notify Community in writing. Upon receipt, all terminations are subject to the terms and conditions of the contract with Community or the Provider’s IPA. Community will notify the Member in writing 30 days prior to the effective day of change. This request will become effective the first day of the month following requests that have been received by the 15th of the month. Requests received after the 15th of the month will become effective on the first day of the second month following the request. This allows Community to efficiently transfer patients to another PCP. Physicians are requested to continue care in progress until all Members can be successfully transferred to a new PCP.

(See under Reporting Changes for more information.)

Responsibility to Verify Member Eligibility and/or Authorizations for Service
It is the responsibility of the treating Provider to verify that the patient continues to be a Community-eligible Member for services during the treatment period. Verify eligibility by:

- Calling Community Member Services at 713.295.6704 or Beacon Health Options for behavioral health services toll-free at 1.855.539.5881.

Referral to Network Facilities and Contractors
To authorize services, please call 713.295.6704 or fax a request to 713.295.2283 (in-patient) or 713.295.2284 (out-patient) or submit an authorization on our Web site at www.CommunityCares.com. Fill out the Community Secure Access Application to become an authorized user. Contact your Provider Engagement Representative to get more information.

Use of Participating Providers and Access to Non-Participating Providers
If a participating Provider chooses to refer a Member for covered services offered by another Provider, the participating Provider must refer the Member only to those Providers who also participate in Community’s Provider network. Participating Providers may identify other participating Providers by accessing Community’s Provider Directory online at www.CommunityCares.com.

In most instances, there are participating Providers available to provide any and all covered services necessary to meet a Member’s overall healthcare needs. Should a participating Provider determine that a Member needs the services of another Provider, yet is unable to identify a Provider within the needed specialty who participates in Community’s Provider network, the participating Provider may request a referral to a Provider who does not participate in Community’s Provider network (out-of-network referral). An out-of-network referral requires prior authorization.

Participating Providers who choose to refer a Member to an out-of-network Provider must obtain prior authorization from Community before referring the Member to an out-of-network Provider. Community’s Medical Affairs or Network Management Department maintains the right to redirect the Member’s care to a participating
Provider if Community feels a participating Provider is licensed and credentialed to render the requested services or Community may redirect the Member to an out-of-network Provider with whom Community maintains a relationship.

A Provider who participates in a Provider network for one of Community’s benefit programs, does not mean that the Provider participates in other Community benefit programs. For example, a Provider in Community’s Medicaid/STAR network may not be in Community’s Health Insurance Marketplace network. When referring a Member for covered services, participating Providers should make sure referrals are made only to those Providers participating in the Provider network affiliated with Community’s benefit program in which the Member is enrolled.

Based upon a Provider’s continued compliance with Community’s Provider network participation criteria, additional needs based on complying with State defined access and availability standards, and/or the outcome of any re-credentialing decision, Community reserves the right to make changes to the list of participating Providers at any time.

**Hospital-Based Providers**

Hospital-based Providers are those who render services exclusively in a hospital-based setting. These Providers include physicians servicing as hospitalists as well as physicians and/or mid-level practitioners practicing in the specialties of Anesthesiology, Emergency Medicine, Radiology, Neonatology, and Pathology. Community asks participating Physicians who admit Members to a participating hospital to notify Members that such hospital-based Providers may render care to the Member during the hospital confinement and that Members may receive statements and/or bills from these hospital-based Providers following the Member’s stay. Members with questions regarding statements or bills from hospital-based Providers may always contact Community’s Member Services at 713.295.6704.

Community does not require authorization for a PCP to refer to any in-network specialist. It is recommended that the PCP call Community Member Services to confirm a specialist’s network status. Community recommends that all PCPs maintain a record of all referrals to specialists.

**Reporting Changes**

Please contact Community’s Provider Relations Department in writing to report any of the following changes:

- Name
- DPS number
- Address
- Permit to practice
- Office hours
- Group affiliation
- Professional liability insurance coverage
- Limits placed on practice
- Status of hospital admission privileges
- Telephone number
- Contract status change
- Specialty change
- Opening/closing of panel
- Tax ID number
- Patient age limitations
- Medicare Provider number
- DEA number
- NPI number
- Addition of any practice and closure of address
- New Provider, Physician Assistant, and Nurse Practitioner in practice
- Other information that may affect current contracting relationship
- Termination of any Healthcare Professional to Physician’s practice
Providers must provide Community 30-day advanced written notice of any changes to the Provider data listed above, as applicable to Provider’s practice or any healthcare professional rendering services under the terms of this agreement. Changes not received in writing are not valid. If Community is not informed within the aforementioned timeframe, Community is not responsible for the potential claims processing and payment errors. Notification of changes should be mailed to:

**Community Health Choice, Inc.**  
Attn: Network Management  
2636 South Loop West, Suite 125  
Houston, TX 77054  
Fax: 713.295.7039  

Behavioral healthcare Providers should direct changes to: Beacon Health Options  
**Provider Operations Department**  
Phone: 1.855.539.5881  
Web site: http://beaconhs.com  

Click on Providers > Provider Relations Contracts > Updating Information to access the online update form.

**Utilization Management**

**Prior Authorization**  
Prior authorization (sometimes referred to as pre-certification or pre-notification) determines whether medical services are as follows:

- Medically Necessary  
- Experimental/Investigational  
- Provided in the appropriate setting or at the appropriate level of care  

**Prior authorization is not a guarantee of payment.** Regardless of whether a Provider obtained the required prior authorization, Community must process a Provider’s claim according to eligibility, contract limitations, and benefit coverage guidelines. Community will determine the payment at the time Community receives a Provider’s claim. The list of services requiring a prior authorization is on the Prior Authorization guide located on the Provider Portal. Go to CommunityCares.com > Provider > Provider Portal.

**Authorization Turnaround Time**

- Routine (Pre-Authorization): 3 business days  
- Urgent (Pre-Authorization): 1 business day  
- Emergent: 1 hour  
- Concurrent (In-Patient): Written, verbal or electronic request – 1 business day  
- Retrospective: 30 business days  
  - May extend by 15 days with notification to Provider – Total of 45 days for information to be submitted  

**Failure to Obtain Prior Authorization or Referral**  
Failure to obtain prior authorization, if required, may result in the denial of payment for covered services. Based on a Provider’s participation agreement, if Community denies payment for service based on Provider’s failure to obtain required prior authorization, Community may review services provided retrospectively to determine if such services were medically necessary. If Community determines that services were medically necessary, Community may adjust the Provider’s original claim denial to allow for payment.

However, the Provider acknowledges that, as a result of not obtaining required prior authorization, Community’s liability for payment shall be limited to 75% of compensation as defined in the Provider’s individual participation agreement.
agreement. Payment for a provision of healthcare services for which Provider does not receive payment as a result of the Provider’s failure to obtain prior authorization are not considered part of Member expense. Provider may ONLY bill a Member for items considered part of Member expense, i.e., copayment, coinsurance, and/or deductible allowed per the Member’s benefit coverage.

**Options for Member Non-Compliance**
Contact Community Provider Relations in the event that a Member:

- Becomes non-compliant
- Becomes abusive to you or your staff
- Continues to demand services that, in your professional judgment, are not medically necessary

Primary Care Provider may request, in writing to Community, that a Member be transferred to another primary care physician for the following reasons:

- Member is disruptive, unruly, threatening or uncooperative to the extent that the Member’s Membership seriously impairs the Provider’s ability to provide services to the Member, provided the behavior is not caused by a physical or behavioral health condition
- Member steadfastly refuses to comply with managed care, such as repeated emergency room use, combined with refusal to allow the Provider to treat the underlying medical condition
- Member steadfastly refuses to comply with prescribed medical treatment that has been prescribed as medically necessary, and the Member has received full, informed consent regarding the prescribed treatment course

A Primary Care Provider must continue to render services 30 days from the date of the letter mailed to the patient and Community.

Remember, physicians are not allowed to withhold or discriminate in any way in the treatment of a Member or to transfer a Member from his/her practice because of the health condition of a Member or the amount of services provided. A Primary Care Provider cannot transfer a Member to another Primary Care Provider without the prior written authorization of Community’s Medical Director. Community requests that the physician continue care until Community can successfully transfer the Member to a new Primary Care Provider’s care.

A Primary Care Provider shall not refuse to accept a Member as a patient on the basis of health status, previous use of services or the medical condition of the Member.

**Routine, Urgent, and Emergent Services**

**Definitions**
Community is committed to ensuring that Members receive timely and appropriate level of access to all levels of care—emergent, urgent, routine, and preventive.

**Emergency Care:** Health care services that are provided in a hospital emergency facility, freestanding emergency medical care facility or a comparable emergency facility in order to evaluate and stabilize medical conditions that have a recent onset and severity, which includes severe pain. It is a medical condition that manifests itself in a manner such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in one or all of the following:

- Place the individual’s health in serious jeopardy
- Serious impairment to bodily functions
- Health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) is in serious jeopardy
• Serious dysfunction of any bodily organ or part
• Serious disfigurement
• Member is a threat to themselves or others; exhibits acute onset of psychosis or severe thought disorganization; risks deterioration from a chronic physical or behavioral health condition that could render the Member unmanageable and unable to cooperate in treatment; or needs assessment and treatment in a safe and therapeutic setting

Emergency room Providers are authorized by Community to provide medically-necessary and appropriate treatment for any Community Member. If a Community Member needs to be admitted, the hospital must notify the Community Medical Affairs Department within 24 hours of the admission or the next business day, by either calling 713.295.6704 or toll-free at 1.855.315.5386, by faxing the encounter record to 713.295.2283 (in-patient) or 713.295.2284 (out-patient) or on our Web site at www.CommunityCares.com. The Primary Care Provider should also be notified by the hospital about the admission within 24 hours or the next business day.

Whenever a Community Member presents to an emergency room with a non-emergent condition, the Member must be assessed and their Primary Care Provider must be contacted (the name of the Primary Care Provider is located on the Member ID card) for appropriate treatment or education.

If the Primary Care Provider or on-call Provider cannot be reached, the hospital should:
• Document attempts to contact the Primary Care Provider
• Treat the Member
• Notify the Primary Care Provider of services rendered by faxing a copy of the encounter to Community at (in-patient) or 713.295.2284 (out-patient). Community will forward a copy to the Primary Care Provider within 24 hours or the next business day. Follow-up care should be referred to the Primary Care Provider.

**Urgent Care:** Hospital admissions and/or treatment that occur in a situation other than an emergency which are provided in settings such as physician or individual Provider’s office or urgent care center due to acute injury or illness that is severe or painful enough to lead a prudent person with an average knowledge of medicine and health, to believe that his/her condition, illness or injury is of such nature that failure to obtain treatment within a reasonable time frame would lead to serious deterioration of the condition of his/her health.

**Acute Care:** Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

**Routine Care (Non-Emergent or Non-Urgent):** Postponement of treatment will not endanger life, limb or mental faculties of patient, i.e., patient’s condition permits adequate time to schedule necessary history and physical, laboratory, radiology or other diagnostic studies on an outpatient basis.

**Preventive Care:** Health services like screenings, checkups, and patient counseling that are used to prevent illness, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best.
Appointment Availability Standards
Community Members are assured timely access to services and availability of Providers within the established standards, as noted below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent Care</td>
<td>Immediate intervention based on medical necessity, including at non-network and out-of-area facilities</td>
</tr>
<tr>
<td>Urgent Care, including urgent specialty care and behavioral health services</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Acute Care, including specialty care and behavioral health services</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Routine Care</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Within 60 days of request for children ages 20 and younger</td>
</tr>
<tr>
<td></td>
<td>Within 90 days of request for adults ages 21 and older</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 14 days of request for initial appointments, except for high-risk pregnancies or new Member in the third trimester, for whom an initial appointment must be offered within five days, or immediately, if an emergency exists. Appointments for ongoing care must be available in accordance to the treatment plan as developed by the Provider</td>
</tr>
<tr>
<td>Dental Injury</td>
<td>Must seek treatment within 24 hours</td>
</tr>
</tbody>
</table>

24-Hour Availability
PCPs are required to provide 24-hour coverage, seven days a week. Arrangements for coverage while off-duty or on vacation are to be made with other participating Providers. Community should be notified of the Provider’s coverage prior to a leave of absence.

Community’s contracts with PCPs state that PCPs must, “be available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, seven days a week.” Additionally, PCP contracts state that PCPs must maintain one of the following to receive calls from Members after normal business hours:

- The office telephone is answered after normal business hours by an answering service, which meets the language requirements of the major population groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the PCP or another Provider designated by the PCP. Someone must be available to answer the designated Provider’s telephone. Another recording is not acceptable.
- The office telephone is transferred after normal business hours to another location where someone will answer the telephone and be able to contact the PCP or another designated individual medical Practitioner who can return the call within 30 minutes.

Emergency Transportation – Ambulance
The ambulance transport is an emergency service for when the condition of the client is life threatening and requires use of special equipment, life-support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility. Facility-to-facility transfers may be considered emergencies if an absence
of immediate medical attention could result in serious impairment, dysfunction or failure of one or more organs or body parts and the required emergency treatment is not available at the first facility. Claims for such transport must document the aforementioned criteria.

**Behavioral Health**

**Definition:**
Behavioral health services are covered services for the treatment of mental and emotional disorders as well as chemical dependency disorders.

An emergency behavioral health condition is any condition, without regard to the nature or cause of the condition, which requires immediate intervention or medical attention. Without this emergency behavioral health treatment or intervention, Members might present an immediate danger to themselves or others or Members may be incapable of controlling, knowing or understanding the consequences of their actions.

Medically-necessary behavioral health services are:

- Reasonable and necessary to diagnose and treat a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare
- Provided in the safest, most appropriate, and least restrictive setting
- Not omitted without adversely affecting the Member’s mental and/or physical health or the quality of care rendered

The mental health priority populations are those individuals served by the local mental health authority (LMHA). This group is defined as children and adolescents, under the age of 18, who exhibit severe emotional or social disabilities that are life-threatening or require prolonged intervention.

Also included in this group are adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic-depressive disorder or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.

**Primary Care Provider Requirements for Behavioral Health**
Community’s Primary Care Providers must screen, evaluate, refer and/or treat any behavioral health problems and disorders for Community Members. The PCP may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues. Community has selected a contracted behavioral health vendor, Beacon Health Options, as our behavioral health services Provider for the treatment of mental health and drug and alcohol abuse issues.

Beacon’s behavioral health toll-free number, 1.855.539.5881, is answered 24 hours a day, seven days a week by qualified mental health professionals who will assist you in identifying an appropriate contracted behavioral health vendor Provider for your patient. The Provider is responsible for maintaining treatment records and obtaining a written medical record release from the Member or a parent/legal guardian of the Member before records can be released.

Community Health Choice follows the Mental Health Parity Addiction Equity Act (MHPAEA). We review to make sure that requirements for mental health benefits are the same or less than medical benefits.
**Referrals for Behavioral Health Services**

All Community Members, including those with disabilities, special healthcare needs or chronic or complex conditions, are allowed direct access to a specialist. The PCP is expected to refer Community Members to contracted behavioral health vendor Providers, as needed, for behavioral health services. If a PCP is unsure whether their patient requires behavioral health services, the PCP is encouraged to refer the patient to a behavioral health specialist to make that assessment by calling Beacon Health Options toll-free at 1.855.539.5881. Community Members may self-refer to behavioral health Providers for treatment.

The PCP’s record will include documentation of behavioral health referrals made and the coordination and communication with behavioral health Providers regarding the Member’s treatment, as would be found for any other specialty referral.

The specialist is expected to communicate with the PCP regarding services rendered as well as results, reports, and recommendations. This is essential to ensure continuity of care for the Member.

The PCP may provide behavioral health-related services within the scope of his/her practice.

**Beacon Health Options PCP Toolkit**

Beacon Health Options, Community Health Choice’s managed behavioral health partner, has developed a toolkit to assist PCPs in the diagnosis and treatment of mental health and substance use disorders. Delivering behavioral health services in a primary care setting can help reduce the stigma and discrimination associated with mental health diagnoses. It’s also more cost effective to treat common behavioral health disorders in primary care settings.

Primary care settings are also becoming the first line of identification for behavioral health issues, and PCPs are the center of care for many patients who have both physical and behavioral health disorders. To support PCPs, this online toolkit will assist in identifying behavioral health conditions through well-known screening tools, as well as decision support. Condition-specific fact sheets, as well as other patient-centered information, are included in the toolkit so PCPs can help their patients understand their diagnosis and take the right steps to become and stay healthy.

Conditions included in the toolkit:

- Alcohol and drugs
- Anxiety
- ADHD
- Depression, adolescent depression, and postpartum depression
- Eating disorders
- OCD
- PTSD
- Schizophrenia

The toolkit also has forms that will allow PCPs to share relevant patient information with other providers, including behavioral health providers, to facilitate better integration of care. Beacon’s PCP toolkit is an excellent resource for PCPs as they diagnose and treat behavioral health conditions.


**Self-Referral**

Community Members may self-refer to any in-network behavioral health Provider. Please contact Beacon Health Options for additional information. Community provides information to Members regarding how and where to obtain behavioral health services.
Clinical Practice Guidelines

As part of its quality-improvement process, Community and Beacon Health Options develop standards and practice guidelines in accordance with:

- Preventive care and acute and chronic care standards utilizing national standards as appropriate to the condition as designated by the Texas Department of Insurance
- Periodic pediatric health screenings based on the Texas Health Steps (THSteps) and
- American Academy of Pediatrics (AAP) standards
- Immunization guidelines based on the Advisory Committee on Immunization Practices
- Prenatal care standards based on the minimum standards of the American College of Obstetricians and Gynecologist (ACOG)

Community consults with network healthcare Providers through the Medical Care Management Committee regarding clinical practice guidelines and policies and procedures related to the quality of clinical care delivered to the HMO enrollees. Community reviews clinical practice guidelines annually and updates them as needed. Community disseminates the guidelines upon request to the Provider network and Members. Guidelines are also on Community’s Web site.

Quality Improvement Program

Overview
The Quality Improvement Program is a comprehensive framework for continuous assessment and improvement of clinical and non-clinical processes and outcomes, by identifying areas of opportunity and implementing new approaches to identify and resolve causes of systematic problems or barriers to improvement.

Quality Improvement Principles
- Community has adopted the Institute for Healthcare Improvement’s Triple Aim approach to optimizing health system performance. Community’s goal is to improve health outcomes for individuals and populations while improving their experience of care and, at the same time, reducing per-capita costs.
- Maintain a quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes.
- Focus on improved Member health outcomes that involve both process outcomes and health outcomes
- Foster teamwork environment where each employee is a contributor to the improvement of processes and outcomes
- Use the Plan-Do-Check-Act (PDCA) model to evaluate the effectiveness of all quality improvement initiatives

Quality Improvement Program focuses on the following areas but is not limited to:
- Health care access
- Health care delivery
- Contracting and contract administration
- Provider credentialing
- Peer review
- Customer service and satisfaction
• Provider service and satisfaction
• Risk minimization
• Utilization management and complex case management
• Care (Disease) management
• Preventive and interventional healthcare services
• Delegation oversight and compliance

**Quality Improvement Committees**

**Executive Quality and Compliance Committee**

The Executive Quality and Compliance Committee (EQCC) is established by the Community Health Choice (Community) Boards of Directors as part of the Quality Management, Performance Improvement and Compliance Programs. The EQCC is designed to be the focal point of management efforts to oversee conformance by Community and its employees with legal, regulatory and contractual requirements applicable to the products offered by Community, and policies and procedures related to its Compliance and Quality Improvement Programs.

Members of EQCC will include all members of the executive management team, including the CEO, Chief Operating Officer (COO), all Vice Presidents and Senior Vice Presidents. The chairperson or other representatives of quality and compliance committees will attend and participate to report any exceptions or items for approval, as needed.

**Quality Optimization Committee**

The Quality Optimization Committee (QOC) has the authority to provide guidance and oversee all activities within the organization that directly influence member health outcomes. The Committee’s guiding philosophy will be the Plan-Do-Check-Act (PDCA) model of continuous improvement.

Specific responsibilities include, but are not limited to:

• Identify and prioritize targeted clinical quality and service measures that need improvement, such as:
  a. Over & Under Utilization
  b. Compliant Trending Data
  c. Care Management (Disease) Data
  d. Complex Case Management Data
  e. HEDIS (Medicaid & QRS)
  f. CAHPS Survey
  g. Provider Satisfaction Survey
  h. Member Line (HHSC & Marketplace/ERS) metrics
  i. Denial/Appeal Data
  j. Annual Population Analysis
  k. Quality Improvement Projects

• Establish and maintain tracking methodologies for measuring targeted health outcomes

• Identify metrics needed for review for accreditation and regulatory oversight

• Utilize the guiding principal of PDCA
  a. Plan – Set specific goals for targeted health measures and make recommendations to accomplish these goals.
  b. Do – Collaborate with relevant departments to implement recommendations.
  c. Check – Analyze the effectiveness of all health outcome improvement initiatives, comparing results to hypothesized outcome and identifying learnings.
  d. Act – Identify future health outcome improvement areas of focus and recommend strategies to garner results
**Accreditation Committee**

The Accreditation Committee serves as an inter-departmental and cross functional workgroup to support the organization in achieving and maintaining adherence to current accreditation standards. Under the authority of its Charter, the responsibilities shall include but are not limited to the following:

- Review of accreditation standards
- Implement accreditation standards through the development of policies & procedures, work processes and other mechanisms.
- Develop and promote a culture of adherence to accreditation standards throughout the organization
- Serve as subject matter experts as it relates to the application of accreditation standards within assigned areas of responsibility
- Partner with the Quality Optimization Committee (QOC) to ensure adequate tracking and trending of data and development of improvement activities required for accreditation efforts. Identify areas of risk of non-compliance with accreditation standards
- Report to Executive Leadership to apprise of progress and identified barriers related to accreditation

**Medical Care Management Committee**

The Medical Care Management Committee (MCMC) is a physician committee responsible for:

- Credentialing decisions for physicians and other providers
- Peer review;
- Review of health plan and delegate documents and policies related to Credentialing, Quality, Care Management, Complex Case Management and Utilization Management
- Review, approval and adoption of clinical practice guidelines.

These actions have been delegated to this committee by the Board of Directors.

Committee members are chosen to reflect the health care needs of Community’s membership and will preferably have prior experience serving in quality management, peer review, and/or credentialing capacities. These members are appointed by the Board of Directors upon recommendation by Medical Affairs and Network Management and serve for an initial 3-year term, with one option to renew their participation for a second 3-year term. A physician participant may be selected for additional terms twelve (12) months following non-participation.

Community participants include Community’s Senior Vice President of Medical Affairs, Community Medical Directors, the Director of Care Management and Community Health, Vice President of Provider Network and Operations or a designee, Vice President of Administration and Legal Affairs, Vice President of Performance Excellence or a designee and the Director of Credentialing.

Community staff participants are not voting members of the committee.

**Provider Engagement Counsel Description**

The Provider Engagement Counsel brings together Providers from diverse specialties and practice settings and serves as a sounding board for Community when considering various administrative, operational or strategic initiatives. The strengthens engagement with Providers, improves transparency in communication, and fosters support in the implementation of new initiatives.
HEDIS® Roadmap Workgroup
The HEDIS® Roadmap is a document Community prepares for our auditor, Attest, to report the hybrid measures for various quality program initiatives related to accreditation and Qualified Health Plan (QHP) measures for the Health Insurance Marketplace. It is a comprehensive document that asks for information about every department within Community and is used to ensure we accurately report HEDIS® measures to HHSC and Centers for Medicare and Medicaid Services (CMS). Membership consists of representatives from Operations, Marketing, Information Technology, Compliance/Risk, Analytics, Marketing, Network Management, Administration and Performance Excellence. The HEDIS Roadmap Workgroup reports to the Quality Optimization Committee (QOC) which reports to the Executive Quality and Compliance Committee (EQCC). The HEDIS Roadmap Workgroup’s specific responsibilities include, but are not limited to:

- Successful completion of the HEDIS Roadmap
- Resolution of all issues identified on the Auditor Issue Log
- Prepare and attend Auditor Onsite Visit
- Resolve any issues identified at the onsite meeting

Delegation Oversight Committee (DOC)
The DOC is chaired by the Vice President of Compliance and Risk Management. The DOC membership consists of the following representatives from various departments: Claims, Call Center Operations, Credentialing, Finance, IT, Provider Relations, Performance Excellence, Contracting (Voting Members of the Delegation Oversight Committee) and VP Corporate Compliance and Risk Management, (Nonvoting Member of the Delegation Oversight Committee).

A representative from Medical Affairs clinical staff and/or a Medical Director will be available as an ad hoc member if a clinical issue arises. Membership is recommended by the Vice President of Compliance and Risk Management and approved annually by EQCC.

The DOC functions include the following:

- Minimum of 4 meetings are held annually and on an ad hoc basis as necessary to review performance measures, compliance, clinical and quality concerns on delegated entities.
- Refers quality recommendations and concerns directly to EQCC
- Updates the EQCC on delegates under Corrective Action Plans and progress made to resolve performance issues
- Refers quality of care issues directly to MCMC
- Meets separately from the EQCC Meeting and with separate meeting minutes
- Maintains minutes of proceedings on quality of care PHI issues in a confidential manner compliant with HIPAA regulations
- Evaluates delegation agreements, audits findings, and routine reporting by delegates
- Reports through the EQCC any findings during site audits for recommendations.

Member Connection Program
The Member Connection Program exists to help Community establish and enhance meaningful and effective two way connections with Members that improve overall health outcomes, well-being, retention and compliance. This program is responsible for establishing and enhancing an interconnected web of Member connection points that are timely, meaningful and effective. The Program is founded on two core beliefs:

1. The sum of all coordinated connection points offers greater value to Members than single touch points delivered in an ad hoc fashion, and
2. On the whole, Members lead healthier, happier lives when they actively participate in their health care.

The Program’s Executive Sponsor is the VP of Marketing and Outreach. Core contributors to the Member
Connection Program include the Creative Director, Call Center Director, Outreach Director, Quality Managers, Medical Affairs Director, and Web Systems Manager. As-needed contributors include Vice President of Marketing and Outreach, Vice President of Performance Excellence, and team members from all departments, as appropriate.

The responsibilities of this Program are:

1. Take initial and ongoing inventory of current member connection points
2. Create strategies to enhance, sustain or discard current connection points to reduce duplication of effort and member frustration, as well as facilitate consistent messaging
3. Identify new opportunities for connection with Members and create strategy to implement selected opportunities
4. Develop methodologies to track and evaluate the effectiveness of individual member connection initiatives, as well as the Program as a whole
5. Communicate progress towards strategic goals to departments and leadership teams
6. Create and enhance “listening tools”, such as focus groups, surveys, qualitative interviews, analysis of member encounter data to inform strategic goals
7. Make recommendations for staffing, funding, training and other resources needed to support Member Connection Program strategic goals
8. Clearly define technology needs that support Program objectives, and collaborate with IT to implement those needs, using an outcomes-focused approach to build vs. buy decisions.

The Member Connections reports directly to the Vice President of Sales and Member Operations.

**Network Assessment Committee (NAC)**

The Network Assessment Committee (NAC) serves as a forum for ensuring cross-departmental input into Community’s strategy for provider network maintenance, compliance, competitiveness, education, and cost efficiency. Participants in the committee will be SVP of Medical Affairs, VP of Provider Operations, VP of Performance Excellence, Director of Contracting, Director of Provider Services, Director of Credentialing & Provider Data Integrity, Director of Contract Administration, Director of Member Services – Medicaid/CHIP, Director of Member Services – Marketplace, Director of Utilization Management, Director of Quality & Outcomes, Director of Pharmacy Analytics, Medical Director(s), and a Representative from Compliance.

The NAC, under the authority of its Charter, provides input or guidance on various topics related to Community’s participating provider network(s) including, but not limited to:

1. Ensuring Employee and Provider awareness of Community’s Provider Engagement Platform, as well as ongoing implementation, evaluation, and adherence to the Provider Engagement Platform
2. Policies and procedures related Provider Participation Criteria, including consistency in, and documentation of, any and all approved exceptions to the requirement for Physicians and Providers to comply with the Provider Participation Criteria
3. Community’s approach for assessing provider network adequacy, including review of all matters related to timely and culturally appropriate Member Access, Appointment, or Availability
4. Community’s strategy and ongoing monitoring and improvement in Provider Data Accuracy in relevant operational systems and in Community’s public-facing provider directory(ies)
5. Efforts to protect Members from any cost sharing or liability resulting from Emergency Out of Network (OON) and/or Plan Directed care
6. Evaluation of participating Physicians’ and Providers’ administrative performance. e.g. compliance with required authorizations, timely claims filing, timely response to Member complaints, etc.
7. Review and approval of all cross-departmental policies, procedures, and various operational efforts impacting Medical Affairs, Network Management, and Member Services, including input and decision making on shared work-flows or processes, e.g. approval of Physicians’ or Providers’ termination from Community’s provider network(s),
8. Evaluation of contracting or network management initiatives aimed at reducing both the administrative expense associated with interactions between Community and participating Physicians and Providers as well as the overall medical loss ratio (MLR) based on contracting or participation efforts, including initial review and strategy considerations for additional value-based contracting

9. Guidance for and Review/Action related to items presented by the Provider Education Leadership Team

10. Guidance for and Review/Action related to items presented by the Provider Engagement Council

The NAC reports directly to the Executive Quality and Compliance Committee (EQCC).

**Standards for Medical Records**

*Accessibility and Availability of Medical Records*

Community includes provisions in contracts with Providers for appropriate access to the medical records of its Members for purposes of quality reviews conducted by the federal Secretary of Health and Human Services, state agencies or any agents thereof.

**Record Keeping**

Medical records may be on paper or electronic. Community takes steps to promote maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review as follows:

**Medical Record Standards:** Community sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

- **Patient Identification Information:** Each page or electronic file in the record contains the patient’s name or patient ID number
- **Personal/Biographical Data:** Include age, sex, address, employer, home and work telephone numbers, and marital status
- All entries are dated and author identified
- The record is legible to someone other than the writer—A second reviewer should evaluate any record judged illegible by one physician reviewer
- **Allergies:** Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
- **Past Medical History (for patients seen three or more times):** Past medical history is easily identified, including serious accidents, operations, and illnesses—For children, past medical history includes prenatal care and birth.
- **Immunizations:** For pediatric records, there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- **Diagnostic Information-Medication Information:** Includes medication information/instruction to Member
- **Identification of Current Problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical record
- **Documentation that the Member (or Member’s caregiver) is provided basic teaching/instructions regarding physical and/or behavioral health condition/tobacco/alcohol/substance abuse. Notation concerning tobacco and alcohol use and substance abuse is present—Abbreviations and symbols may be appropriate
- **Consultations, Referrals, and Specialist Reports:** Notes from any referrals and consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
- **All emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled
- **Prior admissions, as necessary, pertain to admissions which may have occurred prior to Member being
enrolled with Community, and are pertinent to the Member's current medical condition

- **Advance Directive:** For medical records of adults, the medical record documents whether or not the individual has executed an advance directive—An advance directive is a written instruction, such as a living will or durable power of attorney, for healthcare relating to the provision of healthcare when the individual is incapacitated.

- **Documentation of evidence and results of medical, preventive, and behavioral health screening**

- **Documentation of all treatment provided and results of such treatment**

- **Documentation of the team Members involved in the multidisciplinary team of a Member needing specialty care**

- **Documentation in both the physical and behavioral health records of integration of clinical care.** Documentation to include:
  - Screening for behavioral health conditions (including those which may be affecting physical healthcare and vice versa) and referral to behavioral health Providers when problems are indicated
  - Screening and referral by behavioral health Providers to PCPs when appropriate
  - Receipt of behavioral health referrals from physical medicine Providers and the disposition/outcome of those referrals
  - At least quarterly (or more often if clinically indicated) summary of status/progress from the behavioral health Provider to the PCP
  - A written release of information which will permit specific information sharing between Providers
  - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a Member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

In addition, each Provider’s office must have:

- A written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use
- Written procedures for release of information and obtaining consent for treatment

**Patient Visit Data**

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- **History and Physical Examination:** Appropriate subjective and objective information is obtained for the presenting complaints

- **For Members receiving behavioral health treatment, documentation to include “at-risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history)**

- **Admission or initial assessment includes current support systems or lack of support systems**

- **For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased or unchanged during treatment period.**

- **Plan of treatment, which includes activities/therapies and goals to be carried out**

- **Diagnostic Tests**

- **Therapies and Other Prescribed Regimens:** For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.

- **Follow-up:** Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or PRN.

- **Unresolved problems from previous visits are addressed in subsequent visits**

- **Referrals and results**
• All other aspects of patient care, including ancillary services

**Record Review Process**

Community’s record review process assesses the content of medical records for legibility, organization, completion and conformance to its standards. The record assessment system addresses documentation of the items listed in the **Record Keeping** section.

**Claim Submission/Billing**

**Claims Submission**
Claims and/or encounter data must be submitted on the current standard CMS 1500 Form or UB-92/UB 04 to the address designated on the Member’s ID card or specified by the physician’s individual IPA. The Provider’s individual contract supersedes the filing deadlines listed below.

Behavioral health claims must be submitted on the current standard CMS1500 Form or UB-92/UB 04. Behavioral health claims should be mailed to:
Beacon Health Options
Claims Departments
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

**Billed vs. Contracted Charges**
Community reimburses Providers based mainly on the CMS Medicare Fee Schedule. These rates are set by the CMS Medicare Program and are available at www.CMS.gov. Under the rules of the Medicare Program, the Provider is paid the lower of its billed charges or the published Medicaid rate.

**Billed vs. Authorized Diagnosis Related Groups (DRGs)**
For facilities that bill using Diagnosis Related Groups (DRGs), Community follows the CMS Medicare Program rules of reimbursement.

**Emergency Services Claims**
An emergency is defined as any condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a lay person possessing an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical care could result in:

- Placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Causing serious impairment to bodily functions
- Causing serious dysfunction to any bodily organ or part
- Serious disfigurement

**Time Limit for Submission of Claims**
All claims must be submitted within 95 days from the date of service. Claims not filed within 95 days from the date of service may not be considered for reimbursement. Should the physician submit claims using retired or replaced codes, the physician understands and agrees that Community may deny such claims until appropriately coded and resubmitted.

A clean claim is defined as a claim that contains the information reasonably necessary in order to process the claim. The Texas Department of Insurance has defined the specific data elements that will serve to indicate if a claim is clean.
Clean Claims Payment
All clean claims will be adjudicated within 30 days of receipt via electronic submission and 45 days of receipt via non-electronic submissions. A Provider will be notified in writing if additional information is needed to process a claim. Claims submitted by Providers who are under investigation or have been excluded or suspended from State programs for fraud and abuse will not be considered for payment.

Payment shall be within the time limits set forth by the State for network Providers. Payment allowable shall be comparable to what Community pays network Providers, an amount negotiated between Provider and Community or at the usual and customary rate defined by TDI in 28 T.A.C. Section 11.506. Community expects Providers billing for out-of-network emergency care to submit claims within 95 days from the date of service. Community will pay clean claims submitted for out-of-network emergency care within 30 days from Community’s receipt of the claim. Community is in compliance with Texas Department of Insurance policies that regulate claim payments.

All Providers are held responsible for any claims preparation or other activities that may be performed under the Provider’s authority. For example, Providers are held responsible for any omissions and the accuracy of submitted information, even if those actions are performed by office staff, contractors or billing services.

Grace Period Policy
Members for whom Community is not receiving an Advance Premium Tax Credit (APTC) will have a grace period of 30 days, and Members receiving APTC will have a federally-mandated grace period of 90 days in which to make payment for their portion of the premium. Members who enter into the second and/or third month of a 90-day grace period will be flagged accordingly in Community’s online Member eligibility system. Community is required to and will process claims for dates of service during the first 30 days of the 90-day grace period. At this time, Community intends to process claims for dates of service during days 31-90 of a Member’s grace period and will recoup funds, if necessary, from Providers should the Member not make full payment of premiums owed by the 90th day. Community retains the right to pend claims during the second and third month of the grace period as is federally allowable. This policy is subject to change with advance notice and the most current information is available online.

Providers can check a Member’s delinquency status on the Provider Portal. The Member information will be presented on the portal in the manner indicated below.
Claims Filing
Community is in compliance with HIPAA EDI requirements for all electronic transactions. Go to www.CommunityCares.com > Providers > HIM > Provider Participation > HIPAA for a HIPAA companion guide. For additional assistance, please call the Community Provider Hotline at 713.295.6704.

File your claims in one of two ways:

1. **Electronically:**
   Community uses Emdeon and Relay. Our payer ID number is 60495.

2. **Mail:**
   Community Health Choice, Inc.
   P.O. Box 301424
   Houston, TX 77230-1404
   
   Certified mail:
   Community Health Choice, Inc.
   2636 South Loop West, Suite 125
   Houston, TX 77054

Claims Questions/Status
In-network Providers can check claims status, Member eligibility, and a variety of other services online. You must sign up for this service. To learn more, go to www.CommunityCares.com.

To check the status of a claim payment, authorized Providers can either:

1. Contact Community Provider Hotline during regular business hours:
   
   Local: 713.295.6704
   Toll-free: 1.855.315.5386
   Fax: 713.295.7039

2. Submit inquiries in writing to:
   
   Community Health Choice
   Attn: Provider Relations
   2636 South Loop West, Suite 125
   Houston, TX 77054

When calling the Community Provider Hotline, please be prepared to provide the following information:

- Name of the Provider
- Provider NPI number
- Provider Tax ID number
- Member ID number and/or name
- Name of physician rendering the service
- Date(s) of service
- Amount of claim
- Exact problem with claim

Contact Beacon Health Options Member Services for inquiries concerning behavioral health claims toll-free at 1.855.539.5881.
Claims Appeals
Community claims appeals should be sent to:

Community Health Choice, Inc.
Attn: Appeals
2636 South Loop West, Suite 125
Houston, TX 77054

When submitting a claim, please follow these guidelines:

- A separate claim must be completed for each Member and each Provider.
- Allow 45 days for claims processing prior to submitting a duplicate claim.
- If you need to re-file a claim, please mark it as a “CORRECTED CLAIM.” If submitting electronically, mark the electronic field for corrected claims. You may also drop to paper and submit to Community by mail.

Important reminder: No appeal is necessary for corrected claims. Submit to the Community claims address.

Forms to Use
Emergency service claims are required to follow all claims billing procedures. All claims/encounter data should include the following:

1. Required Information for current standard CMS 1500 Claims
   - Patient name
   - Patient date of birth
   - Member’s ID number
   - Subscriber’s name
   - Patient’s relationship to insured
   - Information on any other coverage applicable to the patient
   - If any other insurance on patient, need policy and/or group number
   - Insurance plan name
   - Date of illness, etc. (Maternity claims must include the LMP date)
   - Claims for treatment of an injury must include injury date
   - Referring physician’s name, if applicable
   - ICD-9/10 diagnosis codes

2. Required Information for current standard UB-92/UB 04 Claim Forms
   - Name and address of facility providing the service
   - Patient control number (patient account number)
   - Bill type
   - Tax ID number of the facility providing the service
   - Coverage period
   - Patient’s name and address
   - Patient’s DOB, sex, MS
   - Admission date, admit hour, and discharge hour
   - Discharge status
   - Medical record number
   - Value codes
   - Three-digit revenue code
   - Description
   - HCPCS codes (outpatient claims)
   - Individual service dates (outpatient claims)
   - Number of units
   - Billed charges for each revenue code
   - Total charges
If billing for outpatient surgery revenue codes, please include the corresponding CPT-4 code. The CPT-4 code must be specific; unlisted procedure codes are not acceptable. Claims submitted for outpatient surgery without the CPT-4 code will be denied.

Provider Complaint, Dispute Resolution Process

There are certain dispute resolution provisions in the Provider contract. For the purposes of clarity, Community incorporates the accreditation terminology regarding Administrative and Professional Competence/Conduct disputes. Other types of disputes may include not inviting a Provider to participate in the Community network; immediate termination due to imminent harm and adverse determinations. A detailed description of Community’s Disputes and Appeals policy can be requested by contacting the designated Provider Engagement Representatives. In the event that Community takes an action to terminate, suspend or limit a Provider’s participation status with Community, Community will provide a dispute resolution process as delineated:

- Investigation
- Appeal
- Reapplication Subsequent to Adverse Action

Disputes Involving Administrative Matters

Disputes involving administrative matters are those that arise from non-clinical or administrative issues from or with contracted Providers. Community offers the disputing provider the right to consideration by an authorized representative of the organization not involved in the initial decision that is the subject of the dispute.

Disputes Concerning Professional Competence or Conduct

This section will describe the process Community uses to resolve disputes with participating practitioners/providers regarding actions by the organization that relate to a participating practitioner/provider’s status within the network and any action by the organization related to a practitioner/provider’s professional competency or conduct.

All disputes are referred to a first-level panel consisting of at least three qualified individuals, of which at least one must be a participating practitioner/provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. The practitioner/provider will be notified within 10 days of a determination following the first level panel. The practitioner/provider will have 10 days to request a second level appeal.

If the practitioner/provider is not satisfied with the outcome of the first level appeal, he/she has a right to consideration by a second-level panel consisting of at least three individuals that that were not involved with the first-level panel including at least one participating practitioner/provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute.

The practitioner/provider will be notified in writing within 10 days of the second level appeal panel.

All professional review actions based on reasons related to professional competence or professional conduct that affects or could adversely affect the health or welfare of a patient or patients and that adversely affect a Provider’s privileges for a period of longer than 30 days must be reported, in accordance with Public Law 99-6660 and the Healthcare Quality Improvement Act of 1986. See, 45 CFR 60.9. The process described herein applies to all contracted Providers, delegated and non-delegated. The contracted Provider under a delegated service (e.g., behavioral health) may also have additional specifically-related processes. In compliance with state and
federal regulations, URAC standards, and Community internal standards, Community must report to appropriate monitoring agencies, e.g., the TX Board of Medical Examiners, Health Integrity Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider’s privileges of participation or denial of acceptance to Community’s Provider network. In the event that Community takes an action to terminate, suspend or limit a Provider’s participation status with Community.

**Important Notes**

Regardless of the dispute resolution process described in this policy, automatic and immediate suspension can occur under the following circumstances:

- A practitioner’s state professional license or DEA number is revoked, suspended, restricted or placed under probation
- A practitioner fails to satisfy an interview requirement
- A practitioner fails to maintain malpractice insurance
- A practitioner’s medical records are not completed in a timely manner

**Provider Complaint Process**

A Provider may file a complaint at any time with Community. Complaints should be addressed to the following:

Community Health Choice, Inc.
Attn: Provider Relations
2636 South Loop West, Suite 125
Houston, TX 77054

Community shall acknowledge all written complaints within five business days. If a Provider’s complaint is oral, Community’s acknowledgement letter shall include a one-page Complaint Form.

Community shall acknowledge, investigate, and resolve all complaints not later than the 30th calendar day after the date Community receives the written complaint or one-page complaint form from the complainant.

**Provider Appeals**

**Appeals Adverse Determination**

As a Provider of Community Health Choice, Inc. (Community), you have the right to appeal a Notice of Adverse Determination. An Adverse Determination means that health care services provided or proposed to be provided are not medically necessary, not appropriate or experimental or investigational. This includes services provided and retrospective appeals. The following information will explain how to appeal an Adverse Determination.

*Please note that an appeal to an Adverse Determination does not involve administrative denials, such as incorrect information on a claim (e.g., tax identification number), timely filing or adjustments to paid claims.*

**Standard Appeal Process**

You have the right to appeal an Adverse Determination. You have 180 days calendar days from the date of denial of services or Community’s last Explanation of Payments to file an appeal. You may request your appeal verbally or in writing. The one page appeal form must be submitted with all verbal appeal requests.

Please send all written appeals to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, TX 77054
713.295.2294 or 1.888.760.2600
Fax to: 713.295.7033/Attn: Appeals Coordinator

An enrollee, a person acting on behalf of the enrollee, or the enrollee’s physician or health care Provider may
appeal the adverse determination, orally or in writing for services provided, services not received or services currently being received that are deemed medically unnecessary by the HMO. A written acknowledgement letter is sent within 5 working days on all Standard Appeals once an appeal request is received.

Acknowledgement letters will contain:

- The Appeal Receipt Date
- A list of records the appealing party may wish to submit that will help in the review and the final outcome of the appeal

Community will send a one-page appeal form for all oral appeals received.

Appeal decisions are made by a physician (or dentist, if applicable) who was not involved in the previous adverse determination decision. The physician is of the same or similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal. Appeal resolution letters are mailed to the patient/enrollee or a person acting on the patient/enrollee's behalf and the patient/enrollee's physician or other health care provider and will contain:

a. Dental, medical, contractual reasons for resolution
b. Clinical basis for decision
c. Medical Specialty of the provider consulted
d. Notice of the appealing party's right to seek review by a like specialist
e. Notice of the appealing party's right to seek review by a Texas Department of Insurance (TDI) approved Independent Review Organization (IRO) and procedures for obtaining that review

Specialty Review: If an appeal is denied, only the provider may request, in writing, good cause for having a particular type of specialty provider review the case. A health care provider who is of the same or similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review shall review the decision denying the appeal.

The request must be received within 10 business days. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received. An acknowledgement letter will be sent within five (5) working days of receiving the request for specialty review.

The exhaustion of internal appeals is not necessary if: (a) the internal appeal process timelines are not met; or (b) in an urgent care or life threatening situation, the Member files for an external review before exhausting the internal appeal process.

An appeal resolution letter will be mailed to the patient/enrollee or a person acting on the patient/enrollee's behalf and the patient/enrollee's physician or other health care provider and will contain:

a. Dental, medical, contractual reasons for resolution.
b. Clinical basis for decision.
c. Medical Specialty of the provider consulted.
d. Notice of the appealing party's right to seek review of the denial by an independent review organization and procedures for obtaining that review.

denials of care for life-threatening conditions, emergencies, and continued hospital stays and denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits may be appealed as an expedited appeal. You have 180 days from when you receive this notice to request an appeal. You may request your appeal orally or in writing. Community will send you the one-page appeal form. Although, you are not required to return the completed form we encourage you to do so as it will help us to resolve your appeal.
During the Appeal Process

Community will send an acknowledgment letter concerning your appeal within 5 business days. You have the right to provide us with information that supports your appeal. To prevent a delay in completing your appeal request, please submit all supporting clinical documentation with your appeal. You may request a copy of the criteria used by the physician to reach the final resolution determination.

Answering your Appeal

Community will respond to your appeal within 30 days.

Expedited Appeal Process

You have the right to request an expedited appeal for a denial of emergency care, continued hospitalization and life threatening conditions. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits. This type of appeal is when you feel your patient’s condition could get worse if you wait for the standard appeal process.

You can request an expedited appeal orally or in writing. Because your appeal involves a question of medical necessity, Community will have a physician review the appeal who has not previously reviewed the case, and is of the same or a similar specialty as the health care provider who would typically manages the medical or dental condition, procedure, or treatment under review in the appeal.

Community will respond to your expedited appeal within:

- 1 working day, if your appeal is about emergency or hospital care; or
- 3 working days, for all other expedited appeals.

If you request an expedited appeal, Community will review your request and determine if it meets the definition of an expedited appeal. If your request does not meet the definition of an expedited appeal, we will contact you by telephone and/or fax within 1 working day of our decision. We also send written communication within three working days informing you that your appeal request will be processed according to the standard appeal time frame of 30 days.

Please send your expedited appeal to:

Community Health Choice, Inc.
Attention: Appeals Coordinator
2636 South Loop West, Suite 125
Houston, TX 77054
Fax to 713.295.7033
Attn: Appeals Coordinator
Independent Review Organization (IRO)
If your appeal is denied, you have the right request to an Independent Review Organization (IRO) review. If your member has a life-threatening condition, or receives a denial for prescription drugs or intravenous infusions for which the member is currently receiving benefits, you may bypass our internal appeal process and request an immediate IRO review on behalf of the member. You may also request a quick IRO if we do not meet the time frames for your appeal.

There is no cost to the Provider for an Independent Review. To request an IRO review, you must complete the (LHL009) form and return it to Community Health Choice.

Mail the form to:

Community Health Choice, Inc.
Attention: Appeals Department
2636 South Loop West, Ste. 125
Houston, TX 77054
713.295.6704
Fax to: 713.295.7033
Attn: Appeals Coordinator

Retrospective Adverse Determinations
Adverse determinations related to retrospective reviews will be made within a reasonable period but not to exceed 30 days after the denial of an authorization request. The determination will be sent to the provider, enrollee or a person acting on behalf of the enrollee in writing. The provider has 180 days from the date of the denial letter to request Standard Appeal. Any requests received after 180 days will not be reviewed or processed.
Appeals and External Review Rights

A Provider has a right to appeal any decision Community makes that denies payment on their claim or their request for coverage of a health care service or treatment. Included in the covered person’s rights are the right to appeal an adverse determination to Community and to external review, to appeal a contractual denial, and to file a complaint. Community may not engage in any retaliatory action against a Provider for filing a complaint against Community or appealing an adverse determination. A brief overview of Community’s policy is described below. For a copy of Community’s complete policy, please contact your Provider Representative.

Appeals can be made due to an adverse determination. The Provider also has the right to request a review by an Independent Review Organization. There is no cost to the Provider for the independent review. Appeals can also be made for issues other than adverse determinations. A Member also has the right to request an explanation for an adverse benefit determination or contractual denial. Community members also have the right to file a complaint to Community.

For questions on appeal and external review rights and complaints a Member can call Community's Member Services Department at the number on his/her Member Identification Card.

Community follows Texas Department of Insurance’s guidelines regarding Appeals, Complaints, and External Review Rights policies.

Where to Send Appeals and Requests for IRO

Send appeals and requests for IRO to:

Community Health Choice, Inc.
Attn: Member Appeals Coordinator
2636 South Loop West, Suite 125
Houston, TX 77054
Fax: 713.295.7033/Appeals Coordinator
Phone: 713.295.2294
Toll-free: 1.855.315.5386
TDD: 7-1-1

Send behavioral health care Provider complaints to:

Beacon Health Options
Attn: Complaints Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Filing Complaints with the Texas Department of Insurance

You have the right to file a complaint with TDI. You may report the information to:

Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
1.800.252.3439
Fax: 512.490.1007
Web site: www.tdi.texas.gov
Web site: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov
Exhaustion of Remedies
The Member must complete levels of the Appeal, Complaints, and External Review Rights process applicable to the Member and any regulatory/statutory review process available to the Member under state or federal law before the Member files a legal action.

Key Terms to Understand
1. **“Adverse Determination”** means a determination by Community or a designee that the health care services furnished or proposed to be furnished to a Member are not medically necessary or are experimental, investigational or for research purposes. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. In the case of a prescription drug, it is an adverse determination if Community refuses to provide benefits if the drug is not included in the drug formulary and the Member’s physician has determined that the drug is medically necessary.

2. **“Appeal”** means Community’s formal process by which a Member, an individual acting on behalf of a Member or a Member’s Provider of record may request reconsideration of an adverse determination or adverse benefit determination or contractual denial.

3. **“Complaint”** means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization’s operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. A Complaint does not include: a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a Provider’s or Member’s oral or written expression of dissatisfaction or disagreement with an adverse determination.

4. **“Complainant”** means a Member or a physician, Provider or other person designated to act on behalf of a Member, who files a complaint.

Special Access and Cultural Sensitivity Overview

Special Access Requirements
Providers can communicate with some hearing-impaired Members in writing during office visits. Community can help Providers communicate with the hearing impaired by telephone with a translation device for the deaf. Call Community Member Services TDD/TTY at 7-1-1 for assistance in any language. Some hearing-impaired Members, especially those who became deaf pre-lingual, may not be able to communicate in writing, but can communicate in sign language. If a Community Member needs a face-to-face interpreter in your office, call Community Member Services at least three business days in advance of the Member’s appointment.

Cultural Sensitivity
Cultural sensitivity refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. Community’s interpretive services will help you provide care in a culturally-competent manner.

Members requiring behavioral healthcare services should preferably be referred to treatment Providers who speak the Member’s language and have an understanding of related cultural issues. In the event that a Member requires a behavioral health Provider who speaks another language or has specific expertise with a specific culture, they may contact Beacon Health Options toll-free at 1.855.539.5881 to receive appropriate referrals.
Reporting Provider or Recipient Waste, Abuse or Fraud

A person who intentionally misrepresents material facts by withholding correct information or providing false information necessary to administer the Coverage Contract, can be held liable under fraud, waste, and abuse policies discussed below.

Health insurance fraud may be a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud Community by filing a claim or form that contains a false or deceptive statement may be committing insurance fraud.

If you suspect a client (a person who receives benefits) or a Provider (e.g., doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

You can report Providers/Clients directly to your health plan at:

Community Health Choice
V.P., Compliance & Privacy
2636 South Loop West, Suite 125
Houston, TX 77054
1.877.888.0002

Or go to the Community Web site at www.CommunityCares.com > Provider Participation > Fraud And Abuse.

To report waste, abuse or fraud, gather as much information as possible.

When reporting a Provider (e.g., doctor, dentist, counselor, etc.) provide the following:

- Name, address, and phone number of the Provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Provider—Type of Provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can aid in the investigation
- Dates of events
- Summary of what happened

When reporting a client (a person who receives benefits) provide the following:

- The person’s name
- The person’s date of birth, Social Security Number or case number if available
- The city where the person resides
- Specific details about the waste, abuse or fraud

Pharmacy Benefits/Navitus Health Solutions

Navitus Health Solutions is a full-service pharmacy benefit company committed to lowering drug costs, improving health, and providing superior customer service in a manner that instills trust and confidence. Navitus operates a fully transparent, pass-through model of pharmacy benefit management that delivers extraordinary value and improves Member well-being and optimizes value—as evidenced by their year-over-year drug trend rate, which is consistently well below the national trend, and outstanding generic fill rate.

Navitus delivers comprehensive clinical programs and cost-saving strategies that lower drug costs and promote good Member health. It negotiates drug costs with manufacturers and contracts with most pharmacies. There are over 60,000 pharmacies in the Navitus network. A complete list of participating pharmacies is available on their Web site at www.navitus.com or through Navitus Customer Care, toll-free at 1.866.333.2757.

The Navitus formulary, or preferred drug list, includes prescriptions drugs that are found to be safe and economical by a committee of prescribers and pharmacist called the Pharmacy and Therapeutics (P&T) Committee. The format the formulary includes four tiers of coverage:
• Tier 1 – Formulary generics and lower-cost brand products
• Tier 2 – Preferred brands and higher-cost generics
• Tier 3 – Non-Preferred brand drugs (could include both brand and generic products)
• Tier 4 – Specialty drugs (SP or MSP)

Some medications do require prior authorization. More information about which medications require prior authorization is available on www.navitus.com. On the formulary, medications that require prior authorization for coverage are marked with “PA” next to the medication.

Physicians submit the prior authorization requests. Navitus will review the prior authorization request within 24 hours of receiving complete information from the physician. The Navitus Prior Authorization turn-around is:

• Non-Urgent: 2 business days
• Non-Urgent Exception to Coverage: 5 business days
• Urgent: 1 business day
• Urgent Exception to Coverage: 1 business day

Tablet splitting is a voluntary program in which Navitus may designate certain formulary drugs that the Member can split the tablet of a higher strength dosage at home. Under this program, the Member gets half the usual quantity for a 30-day supply—for example, 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal copayment amount.

Members requesting higher tier drugs when a generic equivalent is available and the physician did not specifically prescribe the requested drug are responsible for the higher tier, cost-sharing amount plus any difference in cost. This cost difference does not apply to any out-of-pocket maximum. If the member or prescriber chooses a brand-name drug when the equivalent generic drug is available on the formulary, the out-of-pocket cost for the filled prescription will be the non-preferred brand cost share plus the difference between the actual cost of the generic drug and the brand-name drug. The out-of-pocket cost for the non-preferred brand plus the additional cost difference are not considered eligible expenses, and therefore, will not accumulate toward the member’s deductible or out-of-pocket maximum. Prior authorization is required when brand is medically necessary and the generic equivalent is available.

The Specialty Pharmacy program is part of the pharmacy benefit and is mandatory after the first fill at retail. Additional information can be found by calling Navitus Customer Care toll-free at 1.866.333.2757. Navitus SpecialtyRx works with a specialty pharmacy to offer services with the highest standard of care. With Navitus SpecialtyRx, delivery of specialty medications is free, and right to the Member’s door or prescriber’s office via FedEx. Local courier service is available for emergency, same-day medication needs. To start using Navitus SpecialtyRx, please call toll-free at 1.855.847.3553. We will work with you for current or new specialty prescriptions.

Navitus has also teamed up with more than 64,000 participating pharmacies across the country to provide immunizations for Members. As a result, Members have easy, convenient access to vaccine services. Vaccines available at participating pharmacies include influenza, tetanus, DTaP, TDaP, and pneumonia. You can find a list of pharmacies participating in this program on the Navitus Web site at www.navitus.com. The formulary list is available online at: www.CommunityCares.com > Health Insurance Marketplace > Drug Formulary.

**Notice to Practitioners:**

Community is committed to making UM decisions based on the following principles:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
Additional Information/Forms

Included are reference information and additional forms in the following order:

- EOC
- Quick Reference Guide
- Prior Authorization Guide
- Provider Address Update Form
- Referral and Authorization Form
- Secure Access Application Form
- Authorization Agreement for Direct Deposit
### Appendix B: Translated Taglines

<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Chinese</td>
<td>本通知有重要信息。本通知包含关于您通过Community Health Choice提交的申请或保险的重要信息。请留意本通知内的重要日期。您可能需要在截止日期之前采取行动，以保留您的健康保险或费用补贴。您有权利以您的母语得到本通知和帮助。请拨打电话1.855.315.5386。</td>
</tr>
<tr>
<td>3. English</td>
<td>This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.</td>
</tr>
<tr>
<td>6. Gujarati</td>
<td>Community Health Choice માં મહત્વપૂર્ણ જાણકારી છે. તમારા આवેદન કે તમારા તંત્રણની મહત્વની તારીખો વિશે તમે જાણી શકો છો. તમારા અર્થ અથવા સ્વાસ્થ્ય સમર્થન તેમજ અંગે શક્તિ આપી શકી શકો છો. તમે અહીંના તમામ જાણકારી તથા સહાય માટે તમારી ભાષામાં મુંબઈમાં 1.855.315.5386 સાથે કોલ કરી શકો છો.</td>
</tr>
<tr>
<td>7. Hindi</td>
<td>इस सूचनाम भ्रमण पूर्ण जानकारी है। इस सूचनाम आपके आवेदन या Community Health Choice के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखें केल्ले खोजिये। आप अपने स्वास्थ्य के केलेक या लागत के मदद के लिए समय सीमारे कार्रवाई करना है। आपके अपनी भाषा में इस जानकारी तथा सहायता में- शुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 बुलाओ।</td>
</tr>
<tr>
<td>8. Japanese</td>
<td>この通知には必要な情報が含まれています。この通知にはCommunity Health Choiceの行申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重行要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1.855.315.5386 までお電話ください。行</td>
</tr>
</tbody>
</table>
### 9. Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1.855.315.5386로 연락하십시오.

### 10. Laotian

<table>
<thead>
<tr>
<th>11. Persian</th>
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<tbody>
<tr>
<td>این اطلاعیه حاوی اطلاعات مهمی می‌باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضا، هزینه و پوشش بیمه‌ای شما می‌باشد. به تاریخ‌های ذکر شده در این اطلاعیه توجه نمایید. به منظور برنوکار نگه‌داشتن پوشش بیمه‌ای باید دریافت کمک‌های مربوط به اقدامات را انجام دهد. حق شماست که این اطلاعات و کمک‌ها بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن 1.855.315.5386 تماس بگیرید.</td>
</tr>
</tbody>
</table>

### 12. Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.855.315.5386.

### 13. Spanish or Spanish Creole

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.855.315.5386.

### 14. Tagalog


### 15. Urdu

آس نوٹس میں اب معلومات ہیں۔ اس نوٹس میں Community Health Choice کے ذریعے آپ کی درخواست ہے۔ اس نوٹس میں اب معلومات ہیں۔ اس نوٹس میں اب تاریخ کے کھیتے ، اپنے مصروفات کی بھی کے تحفظ کو برقرار رکھنے ایک اخراجات میں مدد کے لیے آپ کو پرکھتی نکل کر کاروائی کرنے کے ضرورت پہوپسکی پہ۔ آپ کی معلومات اور سند کو اپنی زبان میں مفت حاصل کریں کا حق حاصل ہے۔ 1.855.315.5386
Appendix B: Translated Taglines


**Non-Discrimination Statement:** Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Care Center at 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

If you need help filing a grievance, Nike Otuyelu, Vice President-Corporate Compliance & Risk Management, is available to help you. You can file a grievance in person or by mail, fax, or email:

Nike Otuyelu, Vice President-Corporate Compliance & Risk Management  
2636 South Loop West, Suite 125  
Houston, Texas 77054  
**Phone:** 713.295.6704  
**Email:** MarketplaceGrievances@communitycares.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 800.537.7697 (TDD)